Comprehensive Case Management for Substance Abuse Treatment
Treatment Improvement Protocol (TIP) Series 27

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The opinions expressed herein are the views of the Consensus Panel members and do not reflect the official position of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized patient care and treatment decisions.

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What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse.

CSAT's Office of Evaluation, Scientific Analysis, and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

The TIPs Editorial Advisory Board, a distinguished group of substance abuse experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Other Drug Abuse Directors to generate topics for the TIPs. Topics are based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://isis.nlm.nih.gov. The move to electronic

media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information.

While each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Comprehensive Case Management for Substance Abuse Treatment*, presents an overview of case management for substance abuse treatment providers. Though they may not refer to it by name, many providers have been using case management for years. What studies support is also proven every day in the field - substance abusers have better treatment outcomes if their other problems are addressed concurrently. As case management becomes the subject of evaluation studies and is increasingly listed as a reimbursable service under managed care, however, more information and a more explicit framework are called for. Chapters 1 and 2 compare the leading models of case management and describe its various functions as practiced within the substance abuse treatment continuum. Chapter 3 provides guidance on establishing linkages with other service agencies, or intra-agency case management. Evaluation of programs, a crucial piece in getting case management funded under managed care, is explicated in Chapter 4. Chapter 5 explains how to use case management to serve an array of special needs substance abuse clients, including those with HIV/AIDS, mentally ill clients, and incarcerated clients. Practical information for adapting a treatment program to a managed care environment is given in Chapter 6. Appendix B is a comprehensive list of knowledge, skills, and attitudes that substance abuse counselors need to perform the case management activities of referral and service coordination. Appendix C is a readiness checklist for providers preparing for managed care.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program

administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debate and discuss their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to the substance abuse treatment field.

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Comprehensive Case Management for Substance Abuse Treatment
Treatment Improvement Protocol (TIP) Series 27

Executive Summary

Case management has been variously classified as a skill group, a core function, service coordination, or a network of "friendly neighbors." Although it defies precise definition, case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. The Consensus Panel that developed this TIP believes that case management lends itself to the treatment of substance abuse, particularly for clients with other disorders and conditions who require multiple services over extended periods of time and who face difficulty in gaining access to those services. This document details the factors that programs should consider as they decide to implement case management or modify their current case management activities. This summary is excerpted from the main text, in which references to the research appear.

Research suggests two reasons why case management is effective as an adjunct to substance abuse treatment. First, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery. Second, treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance abuse. Case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life. Comprehensive substance abuse treatment often requires that clients move to different levels of care or systems; case management facilitates such movement.

Any definition of case management will be contextual, depending on who is implementing the program. Perhaps a more helpful way to understand it is to examine the functions that generally comprise case management: (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy.

Case Management and Substance Abuse Treatment

When implemented to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will

- Provide the client a single point of contact for multiple health and social services systems
- Advocate for the client
- Be flexible, community-based, and client-oriented

- Assist the client with needs generally thought to be outside the realm of substance abuse treatment

To provide optimal services for clients, a treatment professional should possess particular knowledge, skills, and attitudes including

- Understanding various models and theories of addiction and other problems related to substance abuse
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems
- Ability to recognize the importance of family, social networks, community systems, and self-help groups in the treatment and recovery process
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice
- Understanding the value of an interdisciplinary approach to addiction treatment

In addition to the above competencies, treatment professionals must have skills relating to interagency functioning, negotiating, and advocacy. CSAT's Addiction Technology Transfer Centers classify referral and service coordination - basic case management functions - as core competencies for substance abuse treatment providers.

The Substance Abuse Treatment Continuum and Functions of Case Management

The continuum of substance abuse treatment ranges from case finding and pretreatment to primary treatment to aftercare. Although there are distinct goals and treatment activities at each point on the continuum, rarely do clients' needs fit neatly into any one area at a given time; case management serves to span client needs and program structure. Substance abuse treatment and case management functions differ in that treatment involves activities that help substance abusers recognize their problems, acquire the motivation and tools to stay abstinent, and use the acquired tools; case management focuses on helping the substance abuser acquire needed resources. Case management supports a client as he moves through the recovery continuum and reinforces treatment goals.

Interagency Case Management

The goal of interagency case management is to expand the network of services available to clients. All organizations have boundaries to what they can do, and case managers or "boundary spanners" transcend them to facilitate interactions among agencies. In the field of substance abuse, three interagency models have been identified. In the *single agency* model, the case manager personally establishes a series of distinct relationships on an as-needed basis with counterparts in other agencies. In the *informal partnership* model, staff members from several agencies work as a collaborative team, often constituted case by case; *the formal consortium* binds case managers and service providers through formal written agreements. Clearly defined

roles are essential to all three models to ensure that services are coordinated and relevant gaps addressed.

Although informal exchange or "social service bartering" among different agencies is intrinsic to case management, a more formalized connection among agencies sometimes may be required. Examples include memoranda of understanding and interagency agreements and contracts; each of these methods for formalizing expectations can be used in single agency models, informal partnerships, and formal consortia.

To be successful, a case management plan must thoroughly and critically examine community resources to determine what forms of assistance are available and how case management efforts can help clients attain necessary assistance. Many communities have published directories of social, health, welfare, housing, vocational, and other service organizations to help case management programs identify resources, possible provider linkages, and potential gaps in services for their clients. Although such directories are a good starting point, it is important to follow up on the listings to ensure they are still accurate and will be of use to the client.

The Environmental Assessment

Exploring the environment in which an agency operates is crucial to determining the feasibility of an interagency effort. Analysis of the community environment will enhance understanding of the changes that occur among clients, within the program, and in the community. Case management takes place within a dynamic social service environment in which agencies are in constant flux. Programs considering interagency efforts must devise strategies to respond to change while providing continuity for the client. Regular reevaluation helps ensure continued relevance; community service provider networks or consortia are particularly effective in sharing information about changes and developments.

Potential Conflicts

Whenever agencies or service providers work together, the potential for conflict exists. Areas of tension may be present from the very onset of the collaboration. For example, a new project may be viewed by established social service agencies as competition for scarce resources. Sometimes social pressures or the need to maximize resources can force public agencies into joint ventures even if they do not mesh well or have a history of being service competitors. Tensions can also develop in the course of delivering services; for example, interagency collaboration may result in a client having two case managers. Recognizing potential triggers for conflict is a necessary first step in developing a system to handle them. When problems do arise, case managers and other agency personnel can use both informal and formal communication to clarify issues, regain perspective, and refocus the interagency case management process.

Evaluation and Quality Assurance of Case Management Services

Substance abuse treatment programs, including those that receive public funding, are increasingly operating in a managed care environment. In such an environment, policy and clinical decisionmaking rely on outcome data that traditionally describe the impact of case

management and substance abuse treatment interventions in the context of services used and money spent. An additional demand for data comes from public and private payers who want services linked to specific outcomes.

To gauge the effectiveness of case management, indicators of "success" must be defined by the substance abuse program and its stakeholders (including funding and regulatory agencies). In documenting a case management effort, it is necessary to establish *benchmarks* to measure the case management process, for example, recording how often a client shows up at treatment. Once the benchmarks are defined in measurable terms, the next step is to develop and implement a method for measuring practice; that is, to answer the questions, "What are case managers doing, and how does their practice conform to the benchmarks?" Methods of such documentation include

- Maintenance of a simple staff log procedure that measures case managers' activities by contact
- Reviews of case manager client records to evaluate how service planning and referrals adhere to benchmarks
- Interviews or surveys of case managers or clients and their family members to collect information on activities in which case managers engage, to identify how clients' and case managers' views of case management activities differ
- Analysis of data from the agency's management information system (to examine patterns on type, number, and duration of case manager contacts with different target populations).

Measuring System Outcomes

System outcomes are particularly important in a managed care environment, where overall use of expensive services such as hospitalization and residential treatment is strictly monitored. System outcomes can measure cost savings and quality of care: For example, continuity of care is an appropriate measure for a client at risk for relapse after detoxification and before entry into outpatient treatment. Tracking clients within a comprehensive service agency or analyzing data on costs and encounters within a network of agencies are two methods for measuring system outcomes. For such analyses, a computerized management information system (MIS) is essential.

Measuring Client Outcomes

Although "evaluation" is generally considered worthwhile, there is little agreement about the measurement and documentation of specific outcomes for individual clients. Some view a single measure such as sobriety to be the only meaningful indicator of success; others believe success should be gauged against a range of factors, including reduced substance use, improved family functioning, and fewer encounters with the criminal justice system. Until the debate is resolved, programs should identify treatment objectives and extrapolate from them the outcome variables they want to measure.

Anticipating Quality Assurance Data Needs

The types of data required for an evaluation of case management, how the data are collected, and the manner in which data are put to use vary among different stakeholders. It is important to

understand the types of data that various stakeholders need to evaluate the program. Structured feedback loops should be established to ensure that the gathered data are returned to various stakeholders in some meaningful way so that they have an impact on shaping future program development (and future data needs). One of the benefits of the case management approach is that it can be adapted to meet the sometimes contradictory needs of the various stakeholders.

Management Information Systems

A management information system contains all of the case management services information and allows stakeholders to access it. In evaluating a MIS, local programs should

- Determine how to use data already routinely collected by a statewide MIS or a managed care company-based MIS, saving the program from duplicating primary data collection
- Develop or enhance a program-level MIS that tracks data the program needs locally
- Integrate with other computer-based or paper-based systems
- Supply data required by third party payer and governmental bodies

All staff members of a specific program should be stakeholders in the MIS, which increases both system accuracy and the likelihood that a broad array of staff members will use it. If an agency does not have the resources to develop a sophisticated system, it should be able to automate at least a minimum amount of client information through commercially available software. When designing today's MIS, the data requirements of managed care organizations must be addressed.

Future Research

Research centered on case management and the substance abuse field is limited, thus offering local substance abuse programs the opportunity to make significant contributions to the field. Suggested directions for future research include the following:

- Key ingredients of successful programs, especially for hard-to-reach populations
- Relative cost-effectiveness of particular case management models, including cost outcome results within systems incorporating full parity of substance abuse with other health care; outcome results when a full continuum of care is available to patients; and outcome results associated with use of standardized guidelines for placement, continued stay, and discharge for substance abuse patients
- Improved methodology to investigate research questions in "real world" settings
- Development of brief versions of valid and reliable research outcome instrumentation
- The effect of particular forms of case management on societal costs of substance abuse and its treatment
- Cost shifting among health, behavioral health, criminal justice, and other systems that can be accessed by the target population
- Creative ways to use secondary data sets (such as Medicaid and Medicare) to determine trends and patterns of care
- Research questions from broader sociological or multidisciplinary perspectives

Case Management for Clients With Special Needs

Case management is especially appropriate for substance abusers with special treatment needs, related to such issues as HIV infection or AIDS, mental illness, chronic and acute health problems, poverty, homelessness, responsibility for parenting young children, social and developmental problems associated with adolescence and advanced age, involvement with illegal activities, physical disabilities, and sexual orientation. Ideally, a case manager will possess all the expertise and skills needed to treat the many special needs she confronts, but this is unlikely - understanding the ramifications of even one special need can be a staggering task. In the absence of such comprehensive knowledge, a case manager should have a basic foundation of attitudes and skills for delivering services to "special needs clients." The case manager should

- Make every effort to be competent in the special circumstances that affect clients typically referred to a particular substance abuse treatment program
- Understand the range of clients' reactions to the challenges associated with particular special circumstances
- Remain aware of the limits of his own knowledge and expertise
- Evaluate personal beliefs and biases about clients who have special problems or needs
- Maintain an open attitude toward seeking and accepting assistance on behalf of a client
- Know where additional information on special problems can be accessed

Funding Under Managed Care

Whatever treatment providers' attitudes toward managed care, they will have to accept that it is the new paradigm for health care. Well over one-half of the States are currently in the process of adopting some form of managed care for providing public-sector behavioral health care services. Many have already received Federal waivers to implement Medicaid managed behavioral health programs, and other waivers are planned or pending. Managed care has changed the context in which substance abuse treatment services are delivered, and substance abuse programs must prepare to function within this new environment if case management is to survive.

Treatment providers using case management may not only survive but actually thrive under managed care. Many managed care organizations (MCOs) reimburse for case management, so it behooves providers to prove that their brand of case management should be covered. The program should develop a comprehensive case management system with the flexibility and resources necessary to eventually show tangible savings.

To adapt to this new way of doing business, treatment programs must assess how they use case management and appraise their readiness to operate in a managed care environment. One way providers can thrive under managed care is to position themselves and their case management services in a competitive market by identifying market niches, such as clients with HIV/AIDS, criminal justice clients, or older clients.

As MCOs increasingly reimburse for case management, licensing requirements are becoming stricter. The trend is toward case managers who have advanced degrees. Accreditation standards will also tighten under managed care.

In short, there are many reasons for substance abuse treatment providers to adopt case management or to formalize their existing case management activities. This will not necessarily mean an upheaval, as many programs are already helping clients navigate their other, non-substance abuse problems. This TIP equips providers with the knowledge they need to fully serve their clients at the same time they conform to the changing health care system.

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Chapter 1 - Substance Abuse and Case Management: An Introduction

The term *case management* has appeared in social services literature more than 600 times in the last 30 years, referring to everything from the routing of court dockets through the judicial system to the medical management of a hospitalized patient's care. This TIP uses the term to refer to interventions designed to help substance abusers access needed social services.

Support for the use of case management in this setting developed from both clinical practice and empirical observation suggesting that substance abusers who seek treatment have significant problems in addition to using psychoactive substances. Alcohol or other drug use often damages many aspects of an individual's life, including housing, employment, and relationships (Oppenheimer et al., 1988; Westermeyer, 1989). Clients in substance abuse treatment programs, particularly publicly funded treatment programs, present a variety of associated problems. Many use multiple substances and may be poly-addicted. Many suffer from related health disorders, either caused by their substance abuse - such as liver disease and organic brain disorders - or exacerbated by neglect of health and lack of preventive health care. In addition, some diseases - including HIV/AIDS, tuberculosis, and some strains of hepatitis - are transmitted by substance abuse, either directly or indirectly.

Substance abusers also have a higher incidence of mental health disorders than the general population. Up to 70 percent of individuals treated for substance abuse have a lifetime history of depression (Mirin et al., 1988). Between 23 and 56 percent of individuals with diagnosable Axis I mental disorders also have a substance abuse or dependence disorder (Regier et al., 1990).

Substance abuse clients often arrive in treatment programs with numerous social problems as well. Many are unemployed or under-employed, lacking job skills or work experience. Many in publicly funded treatment programs do not have a high school diploma. Some are homeless, and those who have been incarcerated may face significant barriers in accessing safe and affordable housing. Many substance abuse clients have alienated their families and friends or have peer affiliations only with other substance abusers. Women in treatment have often been victims of domestic violence, including sexual abuse; some women in treatment may be living with an abuser. Achieving and maintaining abstinence and recovery nearly always requires forming new, healthy peer associations.

A significant number of clients in treatment are also under some form of control by the criminal justice system. Criminal justice substance abuse clients represent more than half of all clients in treatment in many state and local jurisdictions. Although those afflicted by chemical addiction are found among all socioeconomic groups, persons already plagued by poverty, disease, and unemployment are over-represented (CSAT, 1994). Particularly in publicly funded treatment programs, substance abuse clients have limited resources and may lack health insurance. Many are eligible for publicly supported health and social benefits, including Medicare, food stamps, or welfare.

Data suggest that substance abusers who receive professional attention for these additional problems will see improvements in occupational and family functioning and a lessening of psychiatric symptoms (McLellan et al., 1993; McLellan et al., 1982; Moos et al., 1990; Siegal et al., 1995). Clinicians who develop a "helping alliance" with substance abusers have been shown to produce better treatment outcomes than those who do not (Luborsky et al., 1985).

Why Case Management

Because addiction affects so many facets of the addicted person's life, a comprehensive continuum of services promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual. The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community. Treatment must be structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse. Case management can help accomplish all of the above.

Case management is needed because, in most jurisdictions, services are fragmented and inadequate to meet the needs of the substance-abusing population. This lack of coordinated services results from a variety of factors, including

- Different funding streams. Substance abuse treatment is funded from a variety of sources - block grants, competitive grants, state and local funding, criminal justice funding, and others. The different requirements or goals of these sources can result in a piecemeal approach to programming
- A focus on program funding rather than system funding
- Funding focused on single modalities rather than a continuum of care
- Inadequate funding created by missing pieces in the continuum
- Waiting lists caused by inadequate funding
- Barriers between systems (e.g., mental health vs. substance abuse, criminal justice vs. mental health and substance abuse)
- Lack of incentives geared to client outcome; programs rewarded for process measures, not outcome measures
- Eligibility/admission criteria that exclude certain clients
- Lack of agreement on priority for admission/treatment
- Lack of incentives for programs to work together

Due to the fragmentation of services, the accompanying inefficiency, and a growing scarcity of resources, some form of case management is used with virtually every population that routinely seeks social services. The variability in social services system configurations has led to many different implementations of case management, resulting in conceptual disagreements about case management and difficulty in assessing its value. Inevitably, many of the same issues will arise in the substance abuse setting. This TIP is designed to establish a common starting point for case management work with substance abusers. To address at least some of those conceptual disagreements, the TIP makes several assumptions, including

1. Case management is a set of social service *functions* that helps clients access the resources they need to recover from a substance abuse problem. The functions that comprise case management - assessment, planning, linkage, monitoring, and advocacy - must always be adapted to fit the particular needs of a treatment or agency setting. The resources an individual seeks may be external in nature (e.g., housing and education) or internal (e.g., identifying and developing skills).
2. Advocacy is one of case management's hallmarks. While a professional conducting therapy may speak out on behalf of a client, case management is dedicated to making services fit clients, rather than making clients fit services.
3. Case management may be implemented by an individual dedicated solely to helping the client access needed resources - a case manager - or by a professional who has this responsibility along with therapeutic or counseling functions. This TIP stresses the *intervention* rather than the intervener's *profession.*
4. The primary difference between case management and therapy is that the former stresses resource acquisition, while the latter focuses on facilitating intra- and interpersonal change. However, case management and therapy are not incompatible. Indeed, both are generally called for in addressing the needs of a majority of substance abuse clients.
5. When implemented to its fullest, case management challenges the addiction treatment continuum of pretreatment, primary treatment, and aftercare (discussed further in Chapter 2). This occurs because of the advocacy function of case management; the need for case managers to be flexible, community-based, and community-oriented; and the need for case managers to be the primary figures in planning work with the client.

These assumptions are all affected by the setting in which case management is practiced. Practitioners who work with substance abusers do so in methadone maintenance clinics, hospital- and community-based addiction programs, local social service departments, family preservation programs, and storefront community outreach programs. These physical settings are in turn influenced by numerous other factors, including the source(s) of an agency's funding; the agency's mission; staff orientation, education, and training; the agency's treatment philosophy; and the makeup of other social services in a particular geographical area.

Complicating the implementation of case management with substance abusers are three trends that will alter the current manner in which substance abuse treatment and case management are implemented: Managed care, treatment provided in the criminal justice system, and diminishing social services and resources. Managed care uses case management to *restrict* access to services as well as to *facilitate* access to services. In addition to the issue of cost containment, the movement of a great deal of substance abuse treatment (and thereby case management) into criminal justice venues is significant. The potential conflicts between coerced involvement in

treatment and case management will test the limits of advocacy and client-driven aspects of the intervention. Finally, unlike the early period of case management, clients and professionals practicing case management now negotiate a drastically *constricted* menu of services. Each of these contemporary conditions makes implementation and evaluation an increasingly difficult task.

Case Management - A Brief History

More than 70 years ago when Mary Richmond envisioned a cadre of "friendly neighbors" helping others in their struggles with real world needs (Richmond, 1922), she created not only the field of social work, but case management as well. While she applied the term *social casework* to the activities that affected the adjustment between an individual and the social environment, she could well have been describing the key functions that now comprise case management.

One of the first legislative embodiments of case management occurred in the 1963 Federal Community Mental Health Center Act (Intagliata, 1982) in anticipation of deinstitutionalization, in which persons in long-term psychiatric care were moved into community settings. The expectation that these individuals would need services previously provided in the institution led to the rapid expansion of community-based social services. Unfortunately, these services were often created independently of one another and, coupled with the categorical nature of the eligibility for services, led to difficulties for persons used to having these services provided in institutions. The Community Support System developed by the National Institutes of Mental Health in 1977 envisioned case management as a mechanism for helping clients navigate this fragmented social service system. Accessing these resources would thus enable them to live and function adequately in their communities (Intagliata, 1982; Stein and Test, 1980; Test, 1981; Turner and TenHoor, 1978).

Substance abusers historically were never institutionalized as often as were persons with chronic mental illness and so were not directly impacted by deinstitutionalization legislation. Substance abusers were not generally targeted for the development of categorical systems of service delivery and were not generally recipients of case management services. However, case management-like services were provided to substance abusers under other titles, such as "mission work," and frequently delivered by the clergy or others in skid row missions, detoxification centers, and ad hoc halfway houses. Jails and county work farms were generally the institutions of choice in dealing with this population. Only after substance abuse began to be decriminalized and defined as a disease were substance abusers referred to various social services.

Policymakers in Canada were among the first to translate many generic case management functions into the field of substance abuse treatment, outlining the essential elements of a union of case management and substance abuse treatment (Graham and Birchmore-Timney, 1990; Ogborne and Rush, 1983; Rush and Ekdahl, 1990). Case management for substance abusers initially gained attention in the United States through the Treatment Alternatives for Safe Communities (TASC) program (formerly known as Treatment Alternatives to Street Crime),

which began linking the criminal justice system with the drug abuse treatment system in 1972 and has grown to over 185 programs (Cook, 1992) today.

A 1987 National Institute of Mental Health initiative funded 13 demonstration projects targeted at young adults with coexisting mental health and substance use problems. Of these 13 projects, 10 identified some form of case management as a primary service and provided a general description of the case management intervention (Teague et al., 1990). Initiatives undertaken by both the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) resulted in numerous projects that used case management to enhance treatment (Bonham et al., 1990; Conrad et al., 1993; Cox et al., 1993; Inciardi et al., 1993; Fletcher et al., 1994; Mejta et al., 1994). Case management in these projects was designed to increase retention in the treatment continuum and to improve treatment outcomes.

Definitions and Functions

Any definition of case management today is inevitably contextual, based on the needs of a particular organizational structure, environmental reality, and prior training of the individuals who are implementing it, whether they are social workers, nurses, or case management specialists. Nonetheless, there is relatively widespread agreement on the basic definition, as illustrated in Figure 1-1.

While definitions are useful in guiding general discussions, *functions* are a more helpful way to approach case management as it is actually practiced. As with definitions, there is a high degree of consensus about a core group of functions. One widely accepted set of functions comprises (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy (Joint Commission on Accreditation of Healthcare Organizations, 1979). The National Association of Social Workers' standards for social work case management include assessing, arranging, coordinating, monitoring, evaluating, and advocacy (National Association of Social Workers, 1992).

There is also general agreement about case management functions in the specific context of substance abuse treatment. Case management is one of eight counseling skills identified by the National Association of Alcoholism and Drug Abuse Counselors (National Association of Alcoholism and Drug Abuse Counselors, 1986) and one of five performance domains developed in the Role Delineation Study (International Certification and Reciprocity Consortium, 1993).

Another framework is supplied by the Addiction Technology Transfer Centers (ATTCs), established by CSAT to transmit current information on treatment to providers in the field. The essential elements of case management are laid out in their publication *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 1998). That document has been endorsed by many leading addiction organizations.

Referral and service coordination are two of eight practice dimensions the ATTCs deem essential to the effective practice of addiction counseling. Activities considered part of those two dimensions include engagement; assessment; planning, goal-setting, and implementation; linking, monitoring, and advocacy; and disengagement. The document defines service coordination as:

"The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Service coordination, which includes case management and client advocacy, establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs" (CSAT, 1998, p. 53).

Addiction Counseling Competencies describes the knowledge, skills, and attitudes required for all eight practice dimensions. Those supporting referral and service coordination are reproduced in full in Appendix B.

Models of Case Management With Substance Abusers

Case management models, like the definitions of case management, vary with the context. Some models focus on delivering social services, others on coordinating the delivery of services by other providers. Some provide both. The models result as much from the needs of specific client populations and service settings as they do from distinct theoretical differences about what case management should be. Four models from the mental illness field have been adapted for the field of substance abuse treatment. Each of these models - broker/generalist, strengths-based, assertive community treatment, and clinical/rehabilitation - has proved valuable in treating substance abusers in a particular setting.

For example, the strengths-based approach was adapted to work with crack cocaine users. This approach was chosen not only for its focus on resource acquisition but also because it helps clients see their own assets as a valuable part of recovery (Siegal and Rapp, 1996). Assertive community treatment was implemented to provide parolees a wide range of integrated services, including drug treatment, skills building, and resource acquisition.

Figure 1-2 compares the four models across 11 activities of case management and specifies which models are appropriate for particular substance abuse populations. Implementation of these models may vary with other populations and from setting to setting.

Brokerage/Generalist

Brokerage/generalist models seek to identify clients' needs and help clients access identified resources. Planning may be limited to the client's early contacts with the case manager rather than an intensive long-term relationship. Ongoing monitoring, if provided at all, is relatively brief and does not include active advocacy.

Brokerage/generalist models are sometimes disparaged in discussions of case management because of the limited nature of the client-case manager relationship and the absence of advocacy. Nonetheless, this approach shares the basic foundations of case management and has proved useful in selected situations. The relatively limited nature of the relationship in this model allows the case manager to provide services to more clients. This approach is also appropriate in

instances where treatment and social services in a particular area are relatively integrated and the need for monitoring and advocacy is minimal. The model works best with clients who are not economically deprived, who have significant intent and sufficient resources, or who are not in late-stage addiction. Small agencies or agencies that offer narrowly defined services may be in an ideal position to offer brokerage-only services.

Two creative uses of a brokerage model involved clients who were infected with the human immunodeficiency virus (HIV) or who were at significant risk of acquiring HIV. In one program, case managers also served as educators, delivering cognitive, behaviorally oriented, educational sessions focusing on substance abuse and high-risk behaviors (Falck et al., 1992). The mixing of the educator and case manager roles was intended to increase clients' receptivity to HIV prevention messages by reducing barriers to services that would address problems that might divert attention from those messages. In another variation of the brokerage model, case managers in a large metropolitan area conducted extensive assessments with HIV-infected clients, generally making at least two referrals during the initial session. This "quick response" approach was intended to provide immediate results to clients and to link them with agencies or services that would provide ongoing services (Lidz et al., 1992).

Generalist approaches to working with substance-abusing clients have taken several forms. Case managers in the central intake facility of a large metropolitan area performed the core functions of case management, linking clients with area substance abuse treatment and other human service providers. These case managers had access to funds for purchasing treatment services, thereby drastically reducing waiting periods for these services (Bokos et al., 1993). Another example of a generalist model is Providence, Rhode Island's Project Connect, a family-centered, community-based intervention program designed to address the problems of substance abuse among high-risk families in the child welfare system. Staff members provide intensive home-based counseling services and work with families to obtain other services they may need, including safe and affordable housing and adequate health care.

Assertive Community Treatment

The Program of Assertive Community Treatment (PACT) model, originally developed in Wisconsin (Stein and Test, 1980), emphasizes the following components

- Making contact with clients in their homes and natural settings
- Focusing on the practical problems of daily living
- Assertive advocacy
- Manageable caseload sizes
- Frequent contact between a case manager and client
- Team approach with shared caseloads
- Long-term commitment to clients

Willenbring and his colleagues were among the first to adapt a mental health model for persons with substance abuse problems, specifically chronic public inebriates (Willenbring et al., 1990). Following the tenets of PACT, an individual case manager was closely supported by a core services team that together carried the responsibility for providing services. The model deviated

from the usual approach to dealing with substance abuse clients in two ways. First, instead of expecting clients to come to services when they "hit bottom," case managers sought out clients through a process known as "enforced contact." Second, case managers and the services team acknowledged the chronic nature of the client's condition and sought to modify the course of the condition and to alleviate suffering. The clients were not required to pledge a goal of abstinence.

A derivation of PACT, the Assertive Community Treatment (ACT) model, was used with parolees who had histories of injecting drugs (Martin and Scarpitti, 1993). In this implementation, case managers provided direct counseling services and worked with clients to develop the skills necessary to function successfully in the community. Case management staff also provided family consultations and crisis intervention services and functioned as group facilitators to provide skills training in areas such as work skills, relapse prevention, and education about HIV/AIDS. Departing from the mental health tenets of the PACT model, ACT had time limits and success goals rather than the continuous care envisioned for the mentally ill. Achievement of protracted periods of abstinence and graduation from treatment continuum components were expected of clients (Martin and Scarpitti, 1993). Assertive Community Treatment has been implemented alone and in conjunction with a therapeutic community (Martin et al., 1993).

Strengths-Based Perspective

The strengths-based perspective of case management was originally developed at the University of Kansas School of Social Welfare to help a population of persons with persistent mental illness make the transition from institutionalized care to independent living (Rapp and Chamberlain, 1985). The foremost two principles on which the model rests are (1) providing clients support for asserting direct control over their search for resources, such as housing and employment, and (2) examining clients' own strengths and assets as the vehicle for resource acquisition. To help clients take control and find their strengths, this model of case management encourages use of informal helping networks (as opposed to institutional networks); promotes the primacy of the client-case manager relationship; and provides an active, aggressive form of outreach to clients.

A strengths perspective of case management has been selected for work with substance abusers for three reasons. First is case management's usefulness in helping them access the resources they need to support recovery. Second, the strong advocacy component that characterizes the strengths approach counters the widespread belief that substance abusers are in denial or morally deficient - perhaps unworthy of needed services (Bander et al., 1987; Ross and Darke, 1992). Last, the emphasis on helping clients identify their strengths, assets, and abilities supplements treatment models that focus on pathology and disease. Strengths-based case management has been implemented with both female (Brindis and Theidon, 1997) and male substance abusers (Rapp, 1997; Siegal et al., 1995).

Because of the advocacy component and client-driven goal planning, a strengths-based approach can at times cause stress between a case manager and other members of the treatment team (Rapp et al., 1994). Despite this, there is evidence that the approach can be integrated with the disease model of treatment and that its presence leads to improved outcomes for clients. The

improved outcomes include employability, retention in treatment, and (through retention in treatment) reduced drug use (Rapp et al., in press; Siegal et al., 1996; Siegal et al., 1997).

Clinical/Rehabilitation

Clinical/rehabilitation approaches to case management are those in which clinical (therapy) and resource acquisition (case management) activities are joined together and addressed by the case manager. It has been suggested that the separation of these two activities is not feasible over an extended period of time and that the case manager must be trained to respond to client-focused, as opposed to solely environmental issues (Kanter, 1996). Client-focused services could include providing psychotherapy to clients, teaching specific skills, and family therapy. Beyond the usual repertoire of case management functions (e.g., monitoring), the case manager should be aware of numerous issues including transference, countertransference, how clients internalize what they observe, and theories of ego functioning (Harris and Bergman, 1987; Kanter, 1996).

Many substance abuse treatment programs use a clinical model in which the same treatment professional provides, or at least coordinates, both therapy and case management activities. Such an approach is frequently driven by staffing considerations: It is more economical to have one treatment professional provide all services than to have separate clinical and case managers deliver them.

One example of combining clinical and case management activities is found in a program for women who have substance abuse problems (Markoff and Cawley, 1996). In Project Second Beginning, an emphasis on relationships and empowerment is used both to secure needed resources and to guide implementation of therapy activities. This approach is based on the belief that women have special needs in the treatment setting - needs that can most appropriately be addressed through a therapeutic relationship with a single caregiver. The clinical/rehabilitation approach has been widely used in the treatment of persons with diagnoses of both substance abuse and psychiatric problems (Anthony and Farkas, 1982; Drake et al., 1993; Drake and Noordsey, 1994; Lehman et al., 1993; Shilony et al., 1993).

Comprehensive Case Management for Substance Abuse Treatment
Treatment Improvement Protocol (TIP) Series 27

Chaper 2 - Applying Case Management to Substance Abuse Treatment

Case management is almost infinitely adaptable, but several broad principles are true of almost every application. This chapter will discuss those principles, the competencies necessary to implement case management functions, and the relationship between those functions and the substance abuse treatment continuum. For the purposes of discussion, case management and substance abuse treatment are presented as separate and distinct aspects of the treatment continuum, although in reality they are complementary and at times thoroughly blended.

Case Management Principles

Case management offers the client a single point of contact with the health and social services systems. The strongest rationale for case management may be that it consolidates to a single point responsibility for clients who receive services from multiple agencies. Case management replaces a haphazard process of referrals with a single, well-structured service. In doing so, it offers the client continuity. As the single point of contact, case managers have obligations not only to their clients but also to the members of the systems with whom they interact. Case managers must familiarize themselves with protocols and operating procedures observed by these other professionals. The case manager must mobilize needed resources, which requires the ability to negotiate formal systems, to barter informally among service providers, and to consistently pursue informal networks. These include self-help groups and their members, halfway and three-quarter-way houses, neighbors, and numerous other resources that are sometimes not identified in formal service directories.

Case management is client-driven and driven by client need. Throughout models of case management, in the substance abuse field and elsewhere, there is an overriding belief that clients must take the lead in identifying needed resources. The case manager uses her expertise to identify options for the client, but the client's right of self-determination is emphasized. Once the client chooses from the options identified, the case manager's expertise comes into play again in helping the client access the chosen services. Case management is grounded in an understanding of clients' experiences and the world they inhabit - the nature of addiction and the problems it causes, and other problems with which clients struggle (such as HIV infection, mental illness, or incarceration). This understanding forms the context for the case manager's work, which focuses on identifying psychosocial issues and anticipating and helping the client obtain resources. The aim of case management is to provide the least restrictive level of care necessary so that the client's life is disrupted as little as possible.

Case management involves advocacy. The paramount goal when dealing with substance abuse clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests. Case managers need to advocate with many systems, including agencies, families, legal systems, and legislative bodies. The case manager can advocate by educating non-treatment service providers about substance abuse problems in general and about the specific needs of a given client. At times the case manager must negotiate an agency's rules in order to gain access or continued involvement on behalf of a client. Advocacy can be vigorous, such as when a case manager must force an agency to serve its clients as required by law or contract. For criminal justice clients, advocacy may entail the recommendation of sanctions to encourage client compliance and motivation.

Case management is community-based. All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church. However, the degree of direct community involvement by the case manager varies with the agency. Some agencies mount aggressive community outreach efforts. In such programs, case managers accompany clients as they take buses or wait in lines to register for entitlements. This personal involvement validates clients' experiences in a way that other approaches cannot. It suits the subculture of addiction because it enables the case manager to understand the client's world better, to learn what streets are safe and where drug dealing takes place. This familiarity helps the professional appreciate the realities that clients face and set more appropriate treatment goals - and helps the client trust and respect the case manager. Because it often transcends facility boundaries, and because the case manager is more involved in the community and the client's life, case management may be more successful in re-engaging the client in treatment and the community than agency-based efforts. For clients who are institutionalized, case management involves preparing the client for community-based treatment and living in the community. Case management can ensure that transitions are smooth and that obstacles to timely admissions into community-based programs are removed. Case management can also coordinate release dates to ensure that there are no gaps in service. The type of relationship described here is likely at times to stretch the more narrow boundaries of the traditional therapist-client relationship.

Case management is pragmatic. Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care. Entering treatment may not be a client priority; finding shelter, however, may be. Meeting these goals helps the case manager develop a relationship with and effectively engage the client. This client-centered perspective is maintained as the client moves through treatment. At the same time, however, the case manager must keep in mind the difficulty in achieving a balance between help that is positive and help that may impede treatment engagement. For example, the loss of housing may provide the impetus for residential treatment. Teaching clients the day-to-day skills necessary to live successfully and substance free in the community is an important part of case management. These pragmatic skills may be taught explicitly, or simply modeled during interactions between case manager and client.

Case management is anticipatory. Case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options

available to manage it, and to take appropriate action. In some instances, the case manager may intervene directly; in others, the case manager will take action to ensure that another person on the care team intervenes as needed. The case manager, working with the treatment team, lays the foundation for the next phase of treatment.

Case management must be flexible. Case management with substance abusers must be adaptable to variations occasioned by a wide range of factors, including co-occurring problems such as AIDS or mental health issues, agency structure, availability or lack of particular resources, degree of autonomy and power granted to the case manager, and many others. The need for flexibility is largely responsible for the numerous models of case management and difficulties in evaluating interventions.

Case management is culturally sensitive. Accommodation for diversity, race, gender, ethnicity, disability, sexual orientation, and life stage (for example, adolescence or old age), should be built into the case management process. Five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics of cultural interaction, (4) incorporating cultural knowledge, and (5) adapting practices to the diversity present in a given setting (Cross et al., 1989).

Case Management Practice - Knowledge, Skills, and Attitudes

All professionals who provide services to substance abusers, including those specializing in case management, should possess particular knowledge, skills, and attitudes, which prepare them to provide more treatment-specific services. The basic prerequisites of effective practice include the ability to establish rapport quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, the willingness to be nonjudgmental toward clients, and certain "transdisciplinary foundations" created by the Addiction Technology Transfer Centers (ATTCs). These foundations - understanding addiction, treatment knowledge, application to practice, and professional readiness - are articulated in 23 competencies and 82 specific points of knowledge and attitude. Examples of competencies include

- Understanding a variety of models and theories of addiction and other problems related to substance use
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems
- Recognizing the importance of family, social networks, and community systems in the treatment and recovery process
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice
- Understanding the value of an interdisciplinary approach to addiction treatment (CSAT, 1998)

Even though case managers have not always enjoyed the same stature accorded other specialists in the substance abuse treatment continuum, they must possess an equally extensive body of

knowledge and master a complex array of skills in order to provide optimal services to their clients. Case managers must not only have many of the same abilities as other professionals who work with substance abusers (such as counselors), they must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy. In recognition of the specific competencies applicable to conducting case management functions, two of the eight core dimensions - referral and service coordination - provide critical knowledge, skills, and attitudes pertinent to case management. Below are the activities covered under those dimensions.

Referral

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs
- Continuously assess and evaluate referral resources to determine their appropriateness
- Differentiate between situations in which it is more appropriate for the client to self-refer to a resource and those in which counselor referral is required
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs
- Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through
- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care
- Evaluate the outcome of the referral

Service Coordination

Implement the treatment plan

- Initiate collaboration with referral source
- Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information
- Confirm the client's eligibility for admission and continued readiness for treatment and change
- Complete necessary administrative procedures for admission to treatment
- Establish realistic treatment and recovery expectations with the client and involved significant others including, but not limited to
    - Nature of services
    - Program goals
    - Program procedures
    - Rules regarding client conduct
    - Schedule of treatment activities
    - Costs of treatment
    - Factors affecting duration of care
    - Client rights and responsibilities
- Coordinate all treatment activities with services provided to the client by other resources

Consulting

- Summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress for purpose of ensuring quality of care, gaining feedback, and planning changes in the course of treatment
- Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders
- Contribute as part of a multidisciplinary treatment team
- Apply confidentiality regulations appropriately
- Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies (CSAT, 1998)

Almost 200 specific knowledge items, skills, and attitudes are associated with these dimensions: They can be found in Appendix B.

The Substance Abuse Treatment Continuum and Functions of Case Management

Substance Abuse Continuum of Care

Substance abuse treatment can be characterized as a continuum arrayed along a particular measure, such as the gravity of the substance abuse problem, level of care - inpatient, residential, intermediate, or outpatient (Institute of Medicine, 1990) - or intensity of service (ASAM, 1997). The continuum in this TIP is arranged chronologically, moving from case finding and pretreatment through primary treatment, either residential or outpatient, and finally to aftercare. Inclusion of case finding and pretreatment acknowledges the wide variety of case management activities that take place before a client has actually become part of the formal treatment process.

While distinct goals and treatment activities are associated with each point on the continuum, clients' needs seldom fit neatly into any one area at a given time. For example, a client may need residential treatment for a serious substance abuse problem, but only be motivated to receive assistance for a housing problem. Case management is designed to span client needs and program structure.

Case finding and pretreatment

The case-finding aspect of treatment is generally of paramount concern to treatment programs because it generates the flow of clients into treatment. Pretreatment has changed enormously in the past five years as programs have closed, resources have dwindled, and services available under managed care plans have been severely curtailed. Many individuals identified as viable treatment candidates cannot get through the gate, and pretreatment may in fact constitute brief intervention therapy. Treatment programs may undertake case-finding activities through formal liaisons with potential referral sources such as employers, law enforcement authorities, public welfare agencies, acute emergency medical care facilities, and managed care companies. Health maintenance organizations and managed care companies often require case finding when

hotlines are called. General media campaigns and word of mouth also lead substance abusers to contact treatment programs.

Some treatment programs operate aggressive outreach street programs to identify and engage clients. Outreach workers contact prospective clients and offer to facilitate their entry into treatment. Although treatment admission may be the foremost goal of the worker and the treatment program, prospective clients frequently have other requests before agreeing to participate. Much of the assistance offered by outreach workers resembles case management in that it is community-based, responds to an immediate client need, and is pragmatic.

A pretreatment period is frequently the result of waiting lists or client reluctance to become fully engaged in primary treatment. In a criminal justice setting, it may be a time to prepare clients who are not ready for primary treatment because they do not have support systems in place and lack homes, transportation, or necessary work and living skills. The pretreatment period may be when clients lose interest in treatment. When the appropriate services are provided, however, it may actually increase the commitment to treatment at a later time. Numerous interventions - role induction techniques, pretreatment groups, and case management - have been instituted to improve outcomes associated with the pretreatment period (Alterman et al., 1994; Gilbert, 1988; Stark and Kane, 1985; Zweben, 1981).

Primary treatment

Primary treatment is a broad term used to define the period in which substance abusers begin to examine the impact of substance use on various areas of their lives. The American Society of Addiction Medicine (ASAM) delineates five categories of primary treatment, characterized by the level of treatment intensity: early intervention, outpatient services, intensive outpatient or partial hospitalization, residential or inpatient services, and medically managed intensive inpatient services (ASAM, 1997). Whatever the setting, an extensive biopsychosocial assessment is necessary. This assessment provides both the client and the treatment team the opportunity to determine clinical severity, client preference, coexisting diagnoses, prior treatment response, and other factors relevant to matching the client with the appropriate treatment modality and level of care. If not already established during the case finding/pretreatment phase, this assessment should also consider the client's needs for various resources that case management can help secure.

Aftercare

Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. A client is able to function using a self-directed plan, which includes minimal interaction with a counselor. Counselor interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses. Whether individuals completed primary treatment in a residential or outpatient program, they have at least some of the skills to maintain sobriety and begin work on remediating various areas of their lives. Work is intrapersonal and interpersonal as well as environmental. Areas that relate

to environmental issues, such as vocational rehabilitation, finding employment, and securing safe housing, fall within the purview of case management.

If different individuals perform case management and addictions counseling, they must communicate constantly during aftercare about the implementation and progress of all service plans. Because case managers interact with the client in the community, they are in a unique position to see the results of work being done in aftercare groups and provide perspective about the client's functioning in the community. Recent findings suggest that the case management relationship may be as valuable to the client during this phase of recovery as that with the addictions counselor (Siegal et al., 1997; Godley et al., 1994). Aftercare is important in completing treatment both from a funding standpoint (many funders refuse to pay for aftercare services), as well as from the client's perspective.

Case Management Functions and the Treatment Continuum

In this section, case management functions are presented against the backdrop of the substance abuse continuum of care to highlight the relationship between treatment and case management. The primary difference between the two is case management's focus on assisting the substance abuser in acquiring needed resources. Treatment focuses on activities that help substance abusers recognize the extent of their substance abuse problem, acquire the motivation and tools to stay sober, and use those tools. Case management functions mirror the stages of treatment and recovery. If properly implemented, case management supports the client as she moves through the continuum, encouraging participation, progress, retention, and positive outcomes. The implementation of the case management functions is shaped by many factors, including the client's place in the continuum and level of motivation to change, agency mission, staff training, configuration of the treatment or case management team, needs of the target population, and availability of resources. The fact that not all clients move through each phase of the treatment continuum or through a particular phase at the same pace adds to the variability inherent in case management.

Engagement

Case finding and pretreatment

Engagement during the case finding/pretreatment phase is particularly proactive. The case manager frequently needs to provide services in nontraditional ways, reaching out to the client instead of waiting for the client to seek help. Engagement is not just meeting clients and telling them that a particular resource exists. Engagement activities are intended to identify and *fulfill* the client's immediate needs, often with something as tangible as a pair of socks or a ride to the doctor.

This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services.

Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail or prison have significant life issues that must be addressed simultaneously (such as safe housing, money, and other subsistence issues) as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal activity. Requirements imposed by the criminal justice system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment.

Potential clients may be unfamiliar with the treatment process. Their expectations about treatment may not be realistic, and they may know very little about substance abuse and addiction. It is not uncommon for people at this stage to minimize the impact substance use or abuse has on their lives. These factors often manifest in client behaviors such as missing appointments, continued use, excuses, apathy, and an unwillingness to commit to change.

The goal of case management at this stage is to reduce barriers, both internal and external, that impede admission to treatment. Client reluctance to enter into services can be reduced by (1) motivational interviewing approaches; (2) basic education about addiction and recovery; (3) reminding clients of past and future consequences of continued substance abuse; (4) assistance in meeting the client's basic survival needs; and (5) commitment to developing the case manager-client relationship. Prescreening for program eligibility, coordinating referrals, and working to reduce any administrative barriers can facilitate access to services.

The process of motivating a client, beginning the education process, identifying essential needs, and forming a relationship can begin during a prescreening or screening interview. The motivational approaches suggested by Miller and Rollnick encourage client engagement through exploratory rather than confrontational means (Miller and Rollnick, 1991). Recognizing that not every client enters treatment with the same motivational levels, they build on Prochaska and DiClemente's stages of motivation for treatment. The stages move from the client's non-recognition of a problem (precontemplation) to contemplation of a need for treatment, to determination, to action, and finally, to the maintenance of attained goals (Prochaska and DiClemente, 1982). Case management can use this framework to engage the client with stage-appropriate services. This means that clients who have not decided to address their substance abuse can often be "hooked" into more intensive treatment by providing basic practical supports. Providing these supports can have the additional effect of reducing the perceived desirability of continued substance use and the lifestyles associated with it.

A structured interview provides the client the opportunity to discuss her drug use and history with the case manager and to explore the losses that may have resulted from that use. For some clients, this history may reveal a pattern of increasing loss of control (and perhaps loss of freedom). Review and discussion of losses can serve to motivate clients to proceed to treatment. Listening empathetically and showing genuine concern about a client's well-being can facilitate the beginning of a meaningful, supportive relationship between the client and the case manager and can serve to motivate the client as well. A good initial relationship between client and case manager can also be invaluable when the client experiences difficulties later on in treatment (Miller and Rollnick, 1991).

In addition to information regarding substance abuse and the treatment process, clients must be informed about requirements and obligations of the case manager or case management program, and about requirements they will be expected to meet once they are admitted to treatment. This type of discussion presents another opportunity to solidify the client's commitment to participate in treatment. Even at the earliest stages, clients should be reminded that permanent changes are necessary for recovery. Finally, any questions the client has should be addressed. This can be particularly important for clients referred by the criminal justice system, who may be somewhat confused about that system's requirements, the consequences of noncompliance, and the difficulties they encounter in meeting those requirements.

While case management in the pretreatment phase may be intended to route clients to a particular program, engagement is not just a "come-on" to treatment. Many prospective clients will not formally enter treatment within an agency-defined period, but, within flexible limits, case management services should still be made available to these individuals. The transition from engagement to planning is a gradual one and does not lend itself to agency-created distinctions such as "pretreatment" and "primary treatment."

Primary treatment

For clients who elect to enter treatment, engagement serves to orient the client to the program. Orientation involves explaining program rules and regulations in greater detail than was possible or necessary during pretreatment. The provider elicits the client's expectations of the program and describes what the program expects of the client. The person responsible for delivering case management to a particular client is in a unique position to assist in the match between individual and treatment. During primary treatment, the case manager can serve as one of the client's links with the outside world, assisting the client to resolve immediate concerns that may make it difficult to focus on dealing with the goal of primary treatment - coming to grips with a substance abuse problem.

In addition to orienting clients to treatment programs, case managers can orient treatment programs to the clients they refer. Sharing information gathered during the pretreatment phase can provide support for the treatment process that ensues upon program admission.

Aftercare

While in treatment, most of a client's time is spent dealing with substance use. Although discharge plans may have been considered, it is not until discharge that the day-to-day realities of living assume the most urgency. Because of their relationship with their clients and their community ties, case managers are well positioned to help clients make this delicate transition. Case management serves to coordinate all aspects of the client's treatment. This coordination occurs within a given treatment program, between the program and other resources, and among these other resources. The extent of the case manager's ability to work on the client's behalf will be guided both by the formal authority vested in the individual by the service providers involved and by the individual's informal relationships.

The case manager's extensive knowledge of the client's real-world needs can help the client who is no longer using. Clients in aftercare have an array of needs, including housing, a safe and drug-free home environment, a source of income, marketable skills, and a support system. Many have postponed medical or dental care; in recovery, they may seek it for the first time in years. Once an individual is in recovery, physician-prescribed medication for pain management can become a major problem, an issue that may require coordination and advocacy.

Case Management Functions and the Treatment Continuum

In this section, case management functions are presented against the backdrop of the substance abuse continuum of care to highlight the relationship between treatment and case management. The primary difference between the two is case management's focus on assisting the substance abuser in acquiring needed resources. Treatment focuses on activities that help substance abusers recognize the extent of their substance abuse problem, acquire the motivation and tools to stay sober, and use those tools. Case management functions mirror the stages of treatment and recovery. If properly implemented, case management supports the client as she moves through the continuum, encouraging participation, progress, retention, and positive outcomes. The implementation of the case management functions is shaped by many factors, including the client's place in the continuum and level of motivation to change, agency mission, staff training, configuration of the treatment or case management team, needs of the target population, and availability of resources. The fact that not all clients move through each phase of the treatment continuum or through a particular phase at the same pace adds to the variability inherent in case management.

Engagement

Case finding and pretreatment

Engagement during the case finding/pretreatment phase is particularly proactive. The case manager frequently needs to provide services in nontraditional ways, reaching out to the client instead of waiting for the client to seek help. Engagement is not just meeting clients and telling them that a particular resource exists. Engagement activities are intended to identify and *fulfill* the client's immediate needs, often with something as tangible as a pair of socks or a ride to the doctor.

This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services.

Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail or prison have significant life issues that must be addressed simultaneously (such as safe housing, money, and other subsistence issues) as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal activity. Requirements imposed by the criminal justice

system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment.

Potential clients may be unfamiliar with the treatment process. Their expectations about treatment may not be realistic, and they may know very little about substance abuse and addiction. It is not uncommon for people at this stage to minimize the impact substance use or abuse has on their lives. These factors often manifest in client behaviors such as missing appointments, continued use, excuses, apathy, and an unwillingness to commit to change.

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Case finding and pretreatment

During the pretreatment phase the planning function of case management focuses on supporting clients in achieving immediate needs and facilitating their entry into treatment. Ideally, the professional implementing case management meets with the client to plan the goals and objectives for the service plan. While planning and goal setting are important in this early stage of treatment, it may be difficult to follow traditional approaches given the immediacy of clients' needs and the possibility that they are still using alcohol or other drugs. The case manager may decide to complete a formal plan after an action is undertaken and present it to the client as a summary of work that was accomplished. If a client's capacity is diminished by substance abuse and the presence of multiple, serious life problems, the case manager may have to delay teaching and modeling for the client, and instead trade on his own contacts, resources, and abilities. As the client progresses through the treatment continuum, the case manager can turn more and more of the responsibility for action over to the client.

Clients who are using addictive substances while receiving case management services present a significant dilemma for the case manager. On the one hand, the client may not be willing or able to participate in treatment; on the other, treatment providers normally expect some commitment to sobriety before clients begin the treatment process. As a result, the case manager frequently needs to negotiate common ground between client and program. For example, a case manager might require the client to identify and make progress toward mutually understood goals pending entry into treatment. Structured correctly, such an approach fosters a win-win situation. Attainment of these goals either eliminates the client's need for treatment or prepares him to accept treatment more willingly. Even if the client is unwilling or unable to achieve those goals, the case manager and treatment program have additional information to use in attempting to motivate the client to seek treatment.

Primary treatment

During primary treatment, the case manager and client develop a service plan that identifies and proposes strategies to meet the client's short- and medium-term needs. The case management plan should reflect the level and intensity of the service along with the client's specific objectives. Virtually all clients have multiple needs; consequently, the service plan should be structured to enable clients to focus on addressing their problems *while* they participate in treatment. The idea that one can put lack of housing, employment issues, or a child's illness aside to concentrate exclusively on addiction treatment and recovery is unrealistic and sets up both the treatment provider and the client for failure. At the same time, it is often necessary for the client and case manager to prioritize problems.

During primary treatment, the case manager must (1) continue to motivate the client to remain engaged and to progress in treatment; (2) organize the timing and application of services to facilitate client success; (3) provide support during transitions; (4) intervene to avoid or respond to crises; (5) promote independence; and (6) develop external support structures to facilitate sustained community integration. Case management techniques should be designed to reduce the client's internal barriers, as well as external barriers that may impede progress.

Providing ongoing motivation to clients is critical throughout the treatment continuum. Clients need encouragement to commit to entering treatment, to remain in treatment, and to continue to progress. The case manager must continually seek client-specific incentives. Clients are encouraged by different factors, and the same client may respond differently depending on the situation. For instance, many clients referred by the criminal justice system will be initially motivated to try treatment in order to avoid a jail sentence; they may be motivated to stay in treatment for very different reasons (e.g., they start to feel better, they hope to regain custody of children). The treatment process is difficult, and many clients become discouraged after their initial enthusiasm. Recovery may require them to explore uncomfortable issues. Physical discomfort, as well as depression, can ensue. Case managers can provide support during these periods by supplying information on coping techniques such as exercise, diet, and leisure activities. If depression is significant, case managers can work with substance abuse counselors to have a mental health evaluation conducted, and, if appropriate, enable the client to seek additional therapeutic support for the depression. Continued empathetic caring can also motivate clients.

Disincentives may also be used. For example, the case manager might remind clients of the outcome of terminating treatment - for some, this might mean a return to prison, for others it might mean dealing with the health or safety consequences of addictive behaviors. For clients under the control of the criminal justice system, sanctions, including possible jail stays, may be necessary to regain commitment and motivation.

In criminal justice settings, particularly drug courts, regular "status hearings" before a judge may motivate the client. In status hearings, the judge is informed of the client's progress (or lack thereof), and engages the client in a dialogue. The judge can then apply rewards (encouragement, or reduction of criminal sanctions), adjust treatment requirements, or apply sanctions. Sanctions vary, but may include warnings, community service, short jail stays, or ultimately, termination from the program and incarceration.

Another fundamental role of case management during the active treatment phase is to coordinate the timing of various interventions to ensure that the client can achieve his goals. The case manager has to work with the client to balance competing interests, and to develop strategies so the client can meet basic survival needs while in treatment. For example, a case manager may have to negotiate between probation and treatment to ensure that the client can attend treatment sessions and meet with his probation officer. Some activities require staging to ensure that they are applied at the right time and in the correct order. Clients who are unemployed and lack employment skills, for instance, should begin job readiness and training activities after they are stabilized in treatment; they will need additional support for seeking and maintaining employment. It is not uncommon for clients to feel they can take on the world once they are stabilized in treatment. If this is the case, the job of the case manager is to encourage clients to go slowly and take on responsibility one step at a time. This can be particularly critical for women anxious to reconnect with their children. The financial and emotional responsibilities are great, and the case manager should work with the woman and child protective services to transition these responsibilities in manageable ways.

Transition among programs - from institutional programming to residential treatment; from residential treatment to outpatient; or to lower level services within an outpatient setting - is always stressful, and frequently triggers relapse. In order to avoid crises during transitions, case managers should intensify their contact with clients. Case managers should work to ensure that service is not interrupted. When possible, release dates should be coordinated to coincide with admission to the next program.

If the client is under the control of the criminal justice system, the case manager should work to ensure that supervision activities remain the same or increase when treatment activity decreases. Too frequently, a client completes a treatment program and is moved to a lower level of supervision at the same time. This pulls out support all at once. If possible, supervision and treatment activities should be coordinated to promote gradual movement to independence in order to reduce the likelihood of relapse.

In addition to activities designed to avoid a crisis or relapse, the case manager should be available to respond to relapses and crises when they do occur. In many cases, the case manager leads the response effort. Case managers should be in frequent contact with the treatment program to check on client attendance and progress. Lapses in attendance and/or poor progress can signal an impending crisis, and a case conference should be held. The case conference can resolve problems and prevent the client's termination from the program. While violence toward staff or other patients is obviously adequate grounds for immediate program termination, other infractions do not necessarily warrant expulsion. The case management team and client should work together to develop alternatives that will keep the client engaged in treatment. If removal from the program is absolutely necessary, it may be possible to have the client readmitted after he "adjusts his attitude" and re-commits to treatment and to obeying the rules.

The Treatment Alternatives for Safe Communities (TASC) Project has developed a special form of case conference, known as "jeopardy meetings" for treatment clients involved in the criminal justice system. These meetings are attended by the case manager, treatment counselor, probation officer, client, and anyone else involved in the case. The purpose of the meeting is to confront the client with the problem, and to discuss its resolution as a team. The client must agree to the proposed resolution in writing. The jeopardy meeting provides a clear warning to the client (three jeopardy meetings can result in client termination); reduces the "triangulation" or manipulation that can occur if all parties aren't working in a coordinated fashion; and brings together the skills and resources of multiple agencies and professionals. (For more on jeopardy meetings, including structure and format, see the *TASC Implementation Guide* (Bureau of Justice Assistance, 1988).

Aftercare

One of the anticipatory roles for case management during primary care is to plan for aftercare, discharge, and community reentry. During primary care and into aftercare, the case manager helps the client master basic skills needed to function independently in the community, including budgeting, parenting, and housekeeping. Short-term goals increasingly become supplanted by long-term goals of integrating the individual into a recovery lifestyle. When appropriate, service plans should reflect an ever-increasing emphasis on clients' accepting greater responsibility for

their actions. The case management intervention may increase or decrease in intensity, depending on client response to independence and progress toward community reintegration.

Linking, monitoring, and advocacy

Some findings suggest that while persons with substance abuse problems are generally adept at accessing resources on their own without case management, they often have trouble using the services effectively (Ashery et al., 1995). This is where the linking, ongoing monitoring, and, in many cases, advocacy, of case management can be valuable. An additional crucial function of case management is coordinating all the various providers and plans and integrating them into a unified whole.

Linking goes beyond merely providing clients with a referral list of available resources. Case managers must work to develop a network of formal and informal resources and contacts to provide needed services for their clients.

Case finding and pretreatment

Case managers may be especially active in providing linking and advocacy during the pretreatment phase of the treatment continuum. As with each of the case management functions, the roots of linking begin much earlier, while conducting an assessment with the client and in creating goals in which the client is vested. The authors of one primer on case management identify five tasks related to linking that should be undertaken with the client before actual contact with a needed resource even occurs. Case managers must (1) enhance the client's commitment to contacting the resource; (2) plan implementation of the contact; (3) analyze potential obstacles; (4) model and rehearse implementation; and (5) summarize the first four steps for the client (Ballew and Mink, 1996).

Primary treatment

After the linkage is made, the case manager moves on to monitoring the fit and relationship between client and resource. Monitoring client progress, and adjusting services plans as needed, is an essential function of case management. Coupled with monitoring is the need to share client information with relevant parties. For instance, if a client who is involved in the criminal justice system tests positive for drugs, both the treatment counselor and the probation officer may need to know. If the case manager is aware that the client is having problems at work, this information may need to be shared with the treatment provider, within the constraints of confidentiality regulations.

Case managers who are responsible for offenders in treatment may oversee regular drug testing. This is an effective way to obtain objective information on a client's drug use, as well as to structure boundaries for the client to help prevent relapse.

Monitoring may reveal that the case manager needs to take additional steps on the client's behalf. Simply put, *advocacy* is speaking out on behalf of clients. Advocacy can be precipitated by any one of a number of events, such as

- A client being refused resources because of discrimination, whether discrimination is based on some intrinsic aspect of the client, such as gender or ethnicity, or on the nature of the client's problems, such as addiction
- A client being refused services despite meeting eligibility requirements
- A client being discharged from services for reasons outside the rules or guidelines of that service
- A client being refused services because they were previously accessed but not utilized
- The case manager's belief that a service can be broadened to include a client's needs without compromising the basic nature of the service

Advocacy on behalf of a client should always be direct and professional. Advocacy can take many forms, from a straightforward discussion with a landlord or an employer, to a letter to a judge or probation officer, to reassuring the community that the client's recovery is stable enough to permit reentry. Advocacy often involves educating service providers to dispel myths they may believe about substance abusers, or ameliorating negative interactions that may have taken place between the client and the service provider. This is particularly important for certain groups with whom some programs are reluctant to work, such as clients with AIDS/HIV or clients involved in the criminal justice system.

More complicated advocacy involves, for example, appealing a particular decision by a service staff member to progressively higher levels of authority in an organization. The highest, most involved levels of advocacy include organizing a community response to a particular situation or initiating a legal process. Modrcin and colleagues provide an advocacy strategy matrix that can help case managers systematically plan advocacy efforts (Modrcin et al., 1985). In this view of advocacy, the levels at which advocacy can be effected (individual, administrative, or policy) are weighed against varying approaches (positive, negative, or neutral). Three guidelines for advocating on behalf of a client are getting at least three "No's" before escalating the advocacy effort, understanding the point of view of the organization that is withholding service, and consulting with supervisory personnel regularly before moving to the next level of advocacy (Sullivan, 1991).

Client advocacy should always be geared toward achieving the goals established in the service plan. Advocacy does not mean that the client always gets what she wants. Particularly for clients whose continued drug use or cessation of treatment will present considerable negative consequences such as incarceration or death, advocacy may involve doing whatever it takes to keep them in treatment, even if that means recommending jail to get them stabilized. It is not uncommon, in fact, for clients to state their preference for jail when treatment gets difficult. Even when advocating for clients, the case manger must respect system boundaries. For example, a case manager might negotiate hard to keep an offender client in community-based treatment, but agree to inform the probation office of positive drug tests or suspected criminal behavior. While advocacy for certain client populations is essential, concern for the client should not override goals of public safety. Effective, client-centered advocacy may put the case manager in a position of conflict with co-workers, program administrators, or even supervisors. Case managers who advocate for an extension of benefits for their clients may put themselves and their supervisors in jeopardy with funding sources. A coordinated infrastructure with existing policies and procedures for client centered collaboration will help.

Disengagement

Disengagement in the case management setting, as with clinical termination, is not an event but a process. In some ways, the process begins during engagement. For both client and case manager, it entails physical as well as emotional separation, set in motion once the client has developed a sense of self-efficacy and is able to function independently. To a significant degree, this decision can be based on progress defined by the service plan. If the plan has truly been developed with the client's active involvement, there will be a great deal of objective information that will help both the case manager and client decide when disengagement is appropriate. It is preferable that disengagement be planned and deliberate rather than have the relationship end in a flurry of missed appointments, with no summary of what has been learned by the client and professional. Formal disengagement gives clients the opportunity to explore what they learned about interacting with service providers and about setting and accomplishing goals. The case manager has a chance to hear from clients what they considered beneficial - or not beneficial - about the relationship. Reviewing and summarizing client progress can be an important aspect of consolidating clients' gains and encouraging their future ability to access resources on their own.

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Comprehensive Case Management for Substance Abuse Treatment
Treatment Improvement Protocol (TIP) Series 27

Chapter 3 - Case Management in the Community Context: An Interagency Perspective

The goal of interagency case management is to connect agencies to one another to provide additional services to clients. All organizations have boundaries; case managers or "boundary spanners" move across them to facilitate interactions among agencies (Steadman, 1992). While numerous researchers have investigated the nature of these connections (Tausig, 1987; Van de Ven and Ferry, 1980; DiMaggio, 1986), a 1994 network analysis of the "cracks in service delivery system" provides especially useful insights into the function and impact of various types of community linkages (Gillespie and Murty, l994). According to Gillespie and Murty, agencies can be categorized by the connections they maintain with other community-based agencies. *Isolates*, the first category of agencies or programs, operate self-sufficiently and establish no connections to other organizations in the community. *Peripherals* establish single or limited linkages with other agencies and social providers. A third category of agencies, which the investigators leave unnamed, form effective multiple connections with other organizations.

Applying Gillespie and Murty's classification scheme to substance abuse case management yields three interorganizational models. The three models are

- The single agency
- The informal partnership
- The formal consortium

The *single agency model* is used by such traditional community-based organizations as grassroots domestic violence programs and numerous medically oriented substance abuse treatment agencies. In the single agency model, the case manager personally establishes a series of separate relationships on an as-needed basis with professional colleagues or counterparts in other agencies. The case manager retains full and autonomous control over the case and is accountable only to the parent agency.

In the *informal partnership model*, staff members from several agencies work collaboratively, but informally, as a temporary team constituted to provide multiple services for needy clients on a case-by-case basis. The partnership can involve case managers from two programs or agencies

who consult with one another on problematic cases and exchange resource information. The partnership also can consist of case managers and other types of providers from two or more agencies who meet on an informal basis to integrate and coordinate services in response to clients' needs. Responsibility for a client's well-being is shared, although accountability for the actual services provided remains with the individual agencies.

The *formal consortium model* links case managers and service providers through a formal, written contract. Agencies work together for multiple clients on an ongoing basis and are accountable to the consortium. To ensure coordination among consortium members, a single agency typically takes the lead in coordinating activities and maintains final control over selected resources and interagency processes (Cook, l977). A formal consortium can enhance the systems of care for substance abuse clients. For example, Providence, Rhode Island's Project Connect sponsors a Coordinating Committee that meets monthly on behalf of shared clients. Substance abuse treatment programs, child welfare staff, managed care providers, health care providers, and representatives from the domestic violence community come together to exchange information and coordinate services. This forum offers all participants an opportunity to get to know each other, collaborate, and advocate on behalf of substance abuse-affected families.

Characteristics of the Three Models

All three models describe arrangements for interagency case management services and methods for dispensing them. The most appropriate model for a particular agency or program hinges on its own history and mission, the needs of its clients, and the environment in which it operates. In developing a model, it is important to remember that neither organizations nor environments are static, and interagency models may evolve in complexity from the single agency to the informal partnership to the formal consortium. Although each model has advantages and disadvantages, a model's fit with its clients, the agency, and environmental conditions determines its effectiveness for a particular program (Rothman, 1992). Figure 3-1 summarizes the characteristics, advantages, and disadvantages of each organizational model.

Each model offers distinctive strengths suitable for a particular organizational environment. For example, in rural areas that depend on "one-stop shopping" social service programs, the relatively low-cost single agency focus, with its capacity to respond quickly and authoritatively, may be the optimal choice. On the other hand, the informal partnership tends to deliver more diverse services, so it is better suited to culturally diverse communities. In communities dominated by managed care, a gatekeeper must make referrals for every service, and a formal consortium may be the best choice to supply the necessary documentation.

Besides determining resource acquisition, organizational environments impinge on program decisions in other, less obvious ways. In a volatile environment, a single focus agency with its rapid startup and minimal up-front investment may provide the only sensible alternative. Where shared services can produce savings through economies of scale, the partnership arrangement may maximize scarce resources. In an environment in which program operations are routinely disrupted by political upheaval, a formal consortium with its mandated procedures may provide the stability and continuity necessary to ensure that case management services survive.

Forging the Linkages

Interagency case management arrangements are designed to help providers connect with each other to improve client services and enhance the efficiency of their respective organizations. In addition to trading useful information, agencies also may exchange services, money, clients, and client service slots. In the area of substance abuse treatment, some case managers and addiction specialists may be former users themselves and may have known one another in their former lives (Brown, l991). These ties often strengthen or facilitate interagency exchanges and relations. Seasoned case managers tend over time to form personal working relationships with others in the field and often trade on prior contact, previous service reciprocities, and favors owed to get services for clients (Levy et al., l992). Informal "quid pro quo" arrangements are common, as are shared resources to effect economies of scale.

While this system of informal exchange or "social service bartering" is intrinsic to case management, a more formalized connection among agencies sometimes may be required. Examples include memoranda of understanding (MOUs) and interagency agreements and contracts. Each of these methods for formalizing expectations can be used in single agency models, informal partnerships, and formal consortia.

MOUs are a means to structure a relationship among agencies. When agencies rely heavily on each other's services and function primarily as brokers for their clients, MOUs are essential. They specify such crucial information as the number of service slots that agencies will make available to one another's clients and the consequences for failure to implement or comply with specified activities or procedures. Program managers, rather than case managers, typically draft MOUs and other formal agreements and contracts with staff input. They are particularly useful for

- Ensuring continuity of services during staff turnover
- Clarifying lines of authority and control over various aspects of the case management process
- Recording commitments for providing or funding case management resources (e.g., staffing, operating funds, client referrals)
- Providing a formal record of agencies' agreements and responsibilities
- Holding agencies accountable

MOUs and formal agreements have special appeal when crediting or reporting the outcome or delivery of case management services. Among agencies and service providers that are reimbursed for services on a per capita basis, MOUs can be used to specify which agency or personnel will receive credit. When services are delivered as part of a research project, MOUs can specify who has access to data and who may claim authorship when research results are published.

Some agencies also use Qualified Service Organization Agreements (QSOAs) when an agency or official outside the program provides a service to the program itself. QSOAs might be used, for example, when the program uses an outside entity for laboratory analyses or data processing. MOUs cannot be supplanted by QSOAs.

MOUs and QSOAs are not the only type of formalized agreements available to case managers. Some programs use cooperative service agreements to define what the parties deliver to and receive from each other, and to monitor the programs. A legal contract may be needed when the lead agency in a formal consortium subcontracts to other community-based case management agencies to provide specific services. Many case management agencies also enter into agreements with funding sources, including those providing Federal entitlement benefits. Although some experts question whether case managers should function as payees (that is, accept and monitor entitlement payments on their clients' behalf), a substantial number of case managers take on that role. Until agencies become familiar with such documents and procedures, obtaining counsel prior to signing may be prudent.

Identifying Potential Partners

For any case management plan to be successful, a provider must take a hard, objective look at community resources. What form do they take? What are the barriers to access? Who makes the decisions about how they are used, how are these decisions made, and how can they be obtained? If housing is a major client concern, for example, a community assessment should ascertain if housing assistance is available and how case management efforts might help clients attain it. Similarly, a client's legal status can affect both the number and kinds of services needed (e.g., client involvement in the criminal justice system or with child protective services agencies). Such legal pressures, in turn, determine the range and type of agencies with which a case management program must interact and the conditions for these relationships. Thus, depending on the legal needs of its clients, a case management program may need to identify and forge relationships with such service providers as battered women's shelters, public assistance programs, legal aid, churches, 12-Step groups, and other relevant organizations.

Not all needed services are available, of course, and at times the successful case manager must create them. In other cases, needed resources may exist but prove inaccessible or unacceptable to clients. Ideally, case management agencies or programs want to provide or facilitate the full range of services required by their clients. From a feasibility standpoint, however, most providers must confront painful realities during the assessment process and be prepared to scale back expectations.

Fortunately, most communities already have tools to assist case management programs in identifying resources, possible provider linkages, and potential gaps in services. Public Health Departments, United Way, and county governments frequently produce directories of social, welfare, health, housing, vocational, and other services offered in the community. These often include detailed information about hours, location, eligibility, service mix, and costs; some directories are computerized and regularly updated. Although the costs associated with purchasing these automated directories can be steep (and should be considered when planning the program budget), their timeliness and convenience may justify the investment. In many areas, the Yellow Pages serve as an excellent resource for obtaining initial contact information on a variety of health and social services.

Another solid source of information is *geomapping*, an automated package that assists in resource identification. Philadelphia has developed software that not only provides basic

program information but also indicates whether a particular program has any openings. Traditional paper maps or maps equipped with overlays can fulfill the same function.

While directories and other service rosters provide a useful starting point in identifying potential resources and service providers, additional work is required to determine which listings will prove fruitful. There are often delays in publishing and updating such directories, so that they may be out of date even before dissemination. It is critical that they be updated on a consistent, timely basis. Directories may not list all agencies or programs, and more than one directory may be necessary because an agency's focus can shift.

Ouellet and colleagues report some limitations in using directories, encountered when they developed a case management program for HIV-infected injection drug users (Ouellet et al., 1995). Initially, during startup, staff attempted to link clients to services solely using a service directory, followed by contact with organizations expressing willingness to provide support. Some resulting linkages were found to be "largely useless" because

- Some organizations misrepresent the number or types of services they actually offer or have available
- Many services are poorly financed and disappear quickly
- Some organizations are incompetent or too poorly managed or staffed to provide adequate services
- Some agencies are too far away for clients to use (Ouellet et al., 1995)

In addition, Ouellet noted that some organizations, such as hospitals, stigmatized and treated injection drug users so badly that clients didn't want the services at all. Also, many providers genuinely interested in service collaboration underestimated the number of people seeking help and the breadth of expressed needs, and thus were unable to handle the deluge of service requests. Other organizations had the capability to work with these clients but were unwilling to do so.

To counter such limitations, case management programs often conduct "snowball surveys" in their communities, using one interagency contact to lead to another. This technique can yield insider information about other programs and agencies, their capabilities, and experiences in service use. Identifying and documenting resources and entitlements may be best undertaken during the early phases of program startup, when caseloads are low.

Experienced case management personnel also recommend visiting the programs to which clients will most likely be referred. Onsite visits impart a wealth of information that may confirm or refute the impression conveyed in written materials. They also provide an opportunity to establish valuable contacts with agency personnel who can facilitate client services once the case management collaboration is under way.

Accurate, current information about entitlements is essential for sound interagency case management programs and often can be obtained through local governments. New York City, for example, posts menus of entitlements on electronic kiosks. Many public libraries and local government offices display updated entitlement information regularly. Federal Regional Offices

of agencies such as the Administration for Children and Families are another resource for entitlement information.

As case managers compile and document resources, they should also identify gaps in services so that they and others understand what is available in the community and where advocacy efforts are needed. It is also important to publicize case management programs throughout the community. Brochures, fliers, and simple one-page fact sheets can be used to advertise or explain a program. Announcements on the Internet, in community newspapers, on bulletin boards, and in local civic and professional club newsletters are inexpensive methods for promoting new services. Apprising local police of a new program's existence and the availability of services may be particularly important as their support can prove quite helpful with clients involved in criminal justice matters.

The Agency Environment

Exploring the environment in which an agency operates is essential in determining the feasibility of mounting an interagency case management effort. Several factors influence the provider's ability to conduct case management within the community, including

- **Social service agencies'** number, type, historic responsiveness to clients with substance abuse problems, openness to case management, and relationships with each other. Communities with abundant social service resources that address a wide range of human necessities typically are better able to meet the diverse needs of substance-abusing clients than less endowed communities. Similarly, social service infrastructures in which providers are willing to accept substance abusers as clients and to accommodate innovative approaches to addressing their problems are more likely to welcome an agency's case management initiatives than more restrictive organizational structures.
- **Community leaders' support** for or neglect of substance abuse treatment and their response to case management concepts. Advocacy may be necessary because support or pressure from community and political leaders can facilitate a substance abuse agency's efforts to institute case management. Conversely, implementation can be stalled for months and sometimes stopped entirely in communities when leadership is opposed to substance abuse treatment or case management services for substance abuse clients. Identifying proponents and adversaries is essential in planning strategies that capitalize on support or overcome/sidestep resistance to a case management program. To form a strong supportive voice within a community, provider consortiums are often formed.
- **The economic situation in the community.** The more economically stable a community, the more resources members of the civic, governmental, and corporate power structure have to bring to the table in negotiations with other power brokers on behalf of a case management program or agency.
- **Social climate.** Community acceptance of substance abuse treatment and clients can influence some agencies, particularly those with a grassroots orientation, to accept and cooperate with a case management program. Bottom-up community acceptance can exert a powerful force in gaining agency leadership cooperation, although this outcome may take time.
- **Geographic considerations** (distance, terrain, isolation of the target population from mainstream services). Availability of case management services makes little difference when clients cannot access services because of transportation and other barriers. In fact, accessibility

may determine the specific agencies with which programs are able to connect on behalf of clients.

- **Legal and ethical issues affecting implementation.** Some communities have zoning laws and other legal restrictions specifying which, if any, social service programs can be established within their perimeters or near schools and other public facilities. These statutes need to be clarified before investing in program startup. In addition, clients' possible involvement in the criminal justice system can raise issues of confidentiality and other legal concerns when creating cooperative arrangements with other agencies. Special care needs to be taken when an agency works with clients who are involved with the criminal justice system or who are in any way being coerced or pressured into treatment. Issues that can affect the transfer of confidential or sensitive information need to be carefully worked out before clients are actually admitted for service. Policies and procedures should be regularly reviewed in the face of experience and adjusted accordingly.
- **Funding for program startup and program continuation**. Amount and type of available funding (e.g., multiyear grant, limited foundation support for project startup, and matching or challenge grants) directly bear on the nature and organizational complexity of an agency's case management program. Multiyear funding permits substantial advance planning prior to program implementation. It also enables agencies to bring current and projected resources into negotiations with other community organizations. Continuing funds also allow interagency linkages to develop and improve over time. In contrast, restricted, one-year funding may argue for front-loading resources and selecting a case management model that can be implemented quickly and with immediate short-term payoff.
- **Incentives for entering into an interagency agreement.** Stakeholders who recognize the benefits to their agencies will help facilitate case management. Also, cooperative relations tend to be more stable when participating agencies have much to gain by working together.
- **Volatility of the political, economic, or social environment**, such as the recent introduction of Medicaid managed care. Support for new initiatives can be difficult to obtain in a climate in which reimbursement criteria are being altered, State and Federal funding is being redirected, or political leadership is changing and the new players are unknown. In an uncertain environment, it is critical to justify the cost of a new service with compelling evidence. When chaotic conditions prevail, introducing a case management program gradually protects valuable resources while testing feasibility before full implementation.

Agency administrators, whether they are chief executive officers, executive directors, or program directors, must develop working relationships with the other social and human services agencies with which the case managers will be interacting. To be effective, case management requires that connections be made at the administrative/director levels of agencies. Because case managers may be expected to coordinate and implement a complex service plan in an interagency environment, the case manager needs sufficient power to implement the plan. This comes from the explicit endorsement of an agency's top level administration.

An honest appraisal of the community environment equips an agency or program to make key decisions about interagency case management. Some potential cooperating agencies cannot interact effectively with the larger community or can only provide on-site services. Other agencies may be willing to cooperate, but their organizational missions differ so radically from the case management program's that collaboration is impossible (Ridgely and Willenbring, l992).

Part of the environmental assessment involves identifying such providers to avoid creating linkages that will ultimately prove unworkable.

Analysis of the community environment is one in a series of ongoing assessments aimed at understanding the changes that occur among clients, within the program, and in the community. As is true of other agency activities, case management takes place within a dynamic social service environment in which agencies are in constant flux (Rothman, l992). Programs considering interagency efforts must devise coping strategies to respond to change while providing necessary continuity for the client. In addition, interagency networks are fragile and frequently develop through personal trust established between case managers. Staff turnover disrupts such relationships and threatens the case management system unless guidelines or procedures exist to facilitate a smooth transition (Levy et al., l995).

Because social environments for delivering services do change over time, flexibility and individuation are hallmarks of effective case management. When programs become rigid in their conceptualization, case management services suffer. Regular reevaluation of community resources helps ensure continued relevance.

Finally, the philosophical orientation of a program can affect the efficacy of any interagency arrangements. Understanding a program's history and philosophy helps staff members determine the type of interagency case management services they offer their clients. Compatibility in both program philosophy and organizational structure in forging interagency cooperation is essential, because services suffer when the two clash.

Potential Conflicts

The potential for conflict exists whenever two agencies or service providers work together. Tension may be present from the very onset of the collaboration. For example, existing social service agencies may view a new project as competition for scarce resources (Perl and Jacobs, l992). Or, social pressures or the need to maximize resources can force public agencies into joint ventures even if they don't mesh well or have a history of competitiveness (Alter and Hage, l993). Tensions also can develop in the course of delivering services. Interagency collaboration may result in a client having two case managers, each of whom handles a specialized problem, for example, a case manager from a treatment program and a probation officer. In such instances, manipulative clients may pit one case manager against another - a situation that can become tense for all involved.

Recognizing potential triggers for interagency conflict and antagonism is a necessary first step to dealing with it. When problems do erupt, case managers and other agency personnel can use both informal and formal communication mechanisms to clarify issues, regain perspective, and refocus the interagency case management process. The following list highlights some of the common sources of conflict that may arise as a result of interagency case management.

- Unrealistic expectations about the services and outcomes that case management linkages can produce
- Unrealistic expectations of other agencies

- Disagreements over resources
- Conflicting loyalty between agency and consortium or partnership
- Final decisionmaking and other authority over the management of a case
- Disenchantment after the "honeymoon" period ends
- Differences in values, goals, and definitions of the problem, solutions, or roles (e.g., conflict could arise when police officers working with social service personnel perceive that they are being asked to function as "social workers" and vice versa)
- Dissatisfaction with case handling or other agency's case management performance
- Clients who pit one case manager against another
- Inappropriate expectations of case managers (improper demands, "asking too much")
- Resentment over time spent on documentation, in meetings, or forging and maintaining agency relationships rather than on providing client services
- Stratification, power, and reward differentials among various agency case managers
- Differences in case manager credentials and status among agencies
- Unclear problem resolution protocols for agency personnel

The solution to interagency conflict is open, frank communication by personnel at all levels. Frequent meetings and other activities that bring people together foster such communication. In the long run, the client's welfare is a shared objective, and the difficulties that are likely to arise can be successfully resolved.

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Comprehensive Case Management for Substance Abuse Treatment
Treatment Improvement Protocol (TIP) Series 27

Chapter 4 - Evaluation and Quality Assurance of Case Management Services

Substance abuse treatment programs, including those that receive public assistance, are increasingly operating in a managed care environment. Policymaking and clinical decisionmaking in a managed care environment depend on outcome data that have traditionally described the impact of case management and substance abuse treatment interventions in terms of services used and money spent. (See Chapter 6 for more on implementing case management in a managed care setting.) An additional demand for data comes from public and private payers who want services linked to specific outcomes.

In the past, public sector substance abuse programs were not paid to collect such data and were discouraged from using funds designated for service delivery to conduct evaluations. Consequently, evaluation services often were available only through demonstration grants or through the efforts of university-based evaluators. Today, however, many providers plan, fund, and perform their own evaluations. This reflects both the mandates of funding organizations and agencies' desire to refine or improve their services. To prepare treatment programs to get involved in these efforts, this chapter first presents findings from previous evaluation efforts and then proposes a framework for facilitating quality improvement and other evaluative efforts that consider multiple stakeholders and focus on myriad outcomes and data sources.

A Brief Overview of the Research Literature

Researchers only recently have begun to assess the effectiveness of case management. Studies conducted thus far have suffered from significant methodological problems that include small sample sizes, poorly defined or implemented case management interventions, problems in evaluation design and measurement, lack of distinction between case management and comparison interventions, poor timing, and unaccounted-for contextual factors in communities where case management was studied (Orwin et al., 1994). Problems in research design are more than an academic concern - they render results that may be misleading, difficult to interpret, and unreliable for use in developing case management programs or policy.

Although problems in research design affect other kinds of addiction treatment research, case management is especially difficult to evaluate because contextual factors play a critical role in

program operations. Case management programs do not function in isolation. A key component of a successful case management intervention is the establishment of linkages to other agencies in a service network. Some researchers have suggested that the effectiveness of case management may have more to do with the environment in which it functions than with the functions of the program per se (Ridgely and Willenbring, 1992; Morlock et al., 1988). However, in spite of these difficulties, some useful findings have emerged from work in the mental health and substance abuse fields.

Much of the research on case management has been conducted in the mental health field. Reviews of its effectiveness are mixed (Bond et al., 1995; Chamberlain and Rapp, 1991; Rubin, 1992; Soloman, 1995), revealing the need to identify specific program models and expectations about which type of case management works for particular populations and at what cost (Bond et al., 1995). The Assertive Community Treatment (ACT) model currently appears to have the strongest research base for persons with initially high rates of psychiatric hospitalization, both in terms of increased retention in community based treatment programs and in reduced psychiatric in-patient days (Stein and Test, 1980). This model includes a team of case managers who work with clients in an intensive manner to address problems of daily living and who have a long-term commitment to providing services to clients as long as their needs exist (McGrew and Bond, 1995). While the model appears to be effective in reducing psychiatric hospitalization, there is little evidence that the approach results in improved quality of life or level of functioning for the client (Bond et al., 1995; McGrew and Bond, 1995; Olfson, 1990; Soloman, 1992; Test, 1992).

Evaluation of so-called administrative models in which case managers coordinate services but provide little specific clinical care is inconclusive. Some of these programs improved clients' quality of life but did not interrupt patterns of rehospitalization. However, at least one study revealed that administrative case management both increased the use of services and increased costs for clients without a concomitant measure of improvement in clients' lives (Willenbring et al., 1991).

Few studies have been undertaken on case management in the substance abuse field, and it is difficult to generalize the findings of those studies that have. One study in Canada found results similar to those in mental health studies: There are positive, measurable effects of case management, especially for clients with poor prognostic indicators at admission (such as heavy consumption of alcohol and other drugs, previous treatment failures, and lack of social support) (Lightfoot et al., 1982).

Other studies of case management in the substance abuse field have reported few or no differences for case managed clients compared to those in treatment who do not receive case management services (Inciardi et al., 1994; Falck et al., 1994; Hasson et al., 1994). The authors of those studies, however, speculate that implementation and population issues may have affected outcome. Other studies attribute some of these negative findings not to poor case management interventions, but rather to methodological problems in the evaluations (Orwin et al., 1994).

Even in light of the implementation and methodological concerns about case management research, all the studies together with the findings of other addiction research suggest that case

management can be an effective enhancement to intervention in and treatment of substance abuse. This is especially true for clients with other disorders, who may not benefit from traditional substance abuse treatments, who require multiple services over extended periods of time, and who face difficulty gaining access to those services.

In addition, research suggests two reasons why case management may be effective as an adjunct to substance abuse treatment. First, treatment may be more likely to succeed when "drug use is treated as a complex of symptom patterns involving various dimensions of the individual's life" (Inciardi et al., 1994, p. 146). Case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life. Second, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery and independence (Institute of Medicine, 1990). Studies looking at treatment retention and case management posit a positive relationship between the two (Siegal, 1997; Rapp et al., in press).

Case management's ambitious scope is one of the reasons its effectiveness is difficult to measure. Ashery and others have recommended that practitioners in the field maintain reasonable expectations for case management, pay attention to the implementation of programs, and understand the enhancing or limiting factors of the particular service context in which the case management programs are implemented (Ashery, 1994). The field should consider not only how to best research case management but what to expect from it.

Evaluating Case Management Programs

In order for substance abuse programs to ascertain if case management works, the program and its various stakeholders (including funding and regulatory agencies) must specify and measure outcomes they regard as indicators of success.

This section presents options for basic evaluative methods, including documentation of the case management program's progress and measurement of system and individual client outcomes. It concludes by identifying the data needs of various stakeholders. Whether an evaluation is conducted internally by agency personnel, or by experts hired from outside, front-line case managers are the key source of information.

In documenting a case management effort, it is important to start with *benchmarks* - expectations that are made concrete as measurable statements (e.g., "case managers spend 60 percent of their time in face-to-face contact with their clients"). Some of the sources that programs can use to establish benchmarks include

- Policy and procedure manuals
- Federal, State, and local case management standards
- Agency case management program descriptions and mission statements
- Literature on program models (if the program under evaluation is a replication)
- Consultants

If no written manuals or protocols are available, or if it is clear that the program has drifted from its original design, the program managers and staff may use a consensus-development process to arrive at benchmarks.

Measuring Practice

Once the process benchmarks are defined in measurable terms, the next step is to develop and implement a method for measuring practice - to answer the question, "What are case managers doing and how does their practice conform to the benchmarks?" One approach is to maintain a simple staff log that measures case managers' activities by contact. The information should be comparable to the benchmarks and brief enough to ensure compliance and quality of data. Staff log instruments such as the one used by John Brekke and his colleagues (Brekke, 1987) have been widely adapted and used in the mental health field. They usually record the client's name, location of the contact, duration of the contact, activity, and whether other individuals participated (e.g., staff of other agencies or family members). The brevity and frequency of case managers' contacts with clients makes this measure extremely burdensome, and as a result many programs use time-limited or sampling measures (for example, over a two-week period) to get a "snapshot" of activities.

If time and resources permit, it may be valuable to use several methods of documentation to compare their usefulness and sensitivity. Other methods and purposes include

- Reviews of case manager client records (to evaluate how service planning and referrals adhere to protocols and procedural expectations)
- Interviews or surveys of case managers or clients and their family members (to collect information on activities in which case managers engage, to gauge how clients' and case managers' views of those activities differ)
- Analysis of data from the agency's management information system (to examine patterns on type, number, and duration of case manager contacts with different target populations)

In addition to using multiple methods of documentation, it is important to review case manager activities over time because programs may drift from innovative to familiar patterns of service delivery. In addition, the timing of data collection is crucial. New programs need time to stabilize, and new staff members need a period of orientation before a true picture of program activities can be established.

The key informant survey

Evaluators can use a key informant survey to examine the operations of a program's case management activities. The survey is a fixed series of questions about the functioning of both the case management program and the system of care and is administered to a variety of stakeholders in the community. Different stakeholders are identified by each agency, depending on its particular case management model and the system of care within which it works. Appropriate stakeholders may include, but are certainly not limited to

- Agency staff

- Staff from other substance abuse and human service agencies, homeless shelters, and hospital emergency rooms
- Clients and their family members
- Criminal justice and law enforcement personnel

Survey participants might be asked about their awareness of case management services, their use of these services, types of ongoing contact with the case management program, and their perception of the impact of these services on the community. To ensure a cross section of informed opinion at various points in time, all stakeholders are asked the same questions, and the survey is repeated at several intervals. Such surveys have been used to evaluate systems change in the mental health field (Morrisey et al., 1994) and could be adapted for use in case management programs.

Client satisfaction

Knowing how clients perceive the services they receive is essential to evaluative activities. One can argue that satisfaction with service is related to treatment retention. It is also important to know whether the service provider - in this instance the case manager - and client share a common view of the services being offered and their benefits. For example, did the client feel that the case management services actually led to needed resources? Other questions might focus on client perceptions about those providing the service: Did the case manager understand their needs and have the skills and experience necessary to help them accomplish their goals?

Such process data have direct utility for program management and development. They may help programs with defining staff training needs and assuring that the needs of the population they are working with are being addressed. Such data are also quite useful for those who have the responsibility for funding programs.

Measuring System Outcomes

Many programs in the managed care environment control access to services through what is called "case management," in which gatekeeping procedures are used to limit clients' use of expensive services such as hospitalization and residential treatment. These programs may be particularly interested in measuring *system-level* outcomes to see whether case management has a systemic effect on the delivery of substance abuse and allied services (e.g., change in patterns of service utilization or costs). Thus, a net reduction in the number of inpatient admissions for substance abuse treatment would, by itself, be defined as a positive outcome. This, of course, may not reflect the needs of all clients.

If the goal is preventing clients from "falling through the cracks" between discharge from detoxification and entry into outpatient substance abuse treatment, a system-level outcome might be measured by continuity of care. Greater continuity could be defined as fewer clients with no outpatient treatment episode after a detoxification discharge, patterns showing shorter periods of time between detoxification discharge and outpatient treatment admission, and fewer people with "revolving door" detoxification admissions. Another case management program may aim for increased access to care for certain target populations (for example, cocaine-abusing pregnant

women). In this instance, it would be useful to compare the number of admissions in the target population to all admissions during a specified time period.

In order to measure most system outcomes, it is necessary to track clients within a comprehensive service agency and, if a program's mandate includes managing care across a network of agencies, to gather data on encounters and costs and analyze them. Access to a computerized management information system (MIS) is essential for complete analyses. Although these systems vary widely in their level of sophistication, for this purpose, one must be able to document more than units of service information and should be able to link encounter, claims, and cost data and produce information quickly and easily. Over a period of time, a comprehensive MIS tracks changes in patterns of service utilization and changes in costs, which gives the agency information crucial to management and planning. For example, an MIS that combines utilization and cost data could help identify high utilizers for a program that focuses on clients who use numerous or expensive services. A later section in this chapter describes how a program can evaluate and enhance its MIS system.

Measuring Client Outcomes

While most would agree that "evaluation" is generally worthwhile, there is considerably less agreement about the measurement and documentation of specific outcomes for individual clients. When trying to evaluate case management in an ongoing service agency setting, additional challenges - conceptual, methodological, and ethical - are posed. The field has seen a long-standing and often strident debate about what kinds of outcomes should be measured. Some claim a single measure such as sobriety or complete abstinence from any drug use is the only meaningful measure of treatment success. Others assert that treatment success is most appropriately measured by a constellation of factors, including diminished alcohol and/or other drug use, improved family functioning, improved occupational functioning, less deviant and/or criminal activity, fewer contacts with the criminal justice system, and improvement on a range of psychological variables. The debate will continue. In the meantime, programs should carefully consider treatment objectives to articulate and then operationalize those outcome variables they want to measure.

Another significant complication arises when trying to evaluate case management activities and client outcomes. A program must be able to articulate the role of case management and how it meshes with other program activities. However, when "standard" client outcomes - such as reduced substance use or fewer contacts with the criminal justice system - are measured, it is very difficult to separate the effects of substance abuse treatment activities from the effects of case management activities.

Finally, conducting research in community-based treatment/service organizations presents significant challenges. Experimentation, that is, comparison and control, is at the heart of any scientific research study. One group - typically defined as the "experimental group" - receives one kind of treatment and the control group does not. The two groups are then compared, and conclusions can be reached about the efficacy of the treatment. However, in the context of community-based treatment, a potentially beneficial service like case management cannot be

withheld from some clients. This makes it extremely difficult to definitively attribute specific client outcomes to case management or some other service.

Anticipating Quality Assurance Data Needs

The types of data required for an evaluation of case management, how the data are collected, and the manner in which data are put to use vary among different stakeholders. It is important to understand the types of data that various stakeholders need to evaluate the program. Structured feedback loops should be established to ensure that the data gathered are returned to various stakeholders in some meaningful way so that they have an impact on shaping future program development (and future data needs). One of the benefits of the case management approach is that it can be adapted to meet the sometimes contradictory needs of the various stakeholders.

Data needs of case managers

Although the data needs of case managers may vary from agency to agency, rapid access to data in three particular areas is critical:

- Information about clients currently on the caseload (roster management), including outcome data so case managers have feedback on their performance
- Data that allow case managers to track clients through various services
- Data that produce "flags" for follow-up letters, aftercare, and other time-sensitive functions

In addition to these elements, case managers with gatekeeping or budgeting responsibility need overall service utilization and cost figures by client in order to manage services within a budget. To evaluate process, case managers need access (preferably computerized) to referral networks, bed allocation systems, progress notes, and data related to the daily conduct of their jobs. In terms of outcome data, case managers may want rapid access to client status, especially if it would prompt additional efforts.

Data needs of program managers

Program managers must ensure that the data collected reflect the program mission and facilitate the program's management. While the case manager focuses on individual clients, the program manager analyzes data elements to see patterns and to flag and investigate "outliers" - those who deviate drastically from the statistical norms of the population.

The initial data needs of program managers reflect concerns with concrete aspects of program operation. To program managers, case management essentially begins when the phone rings, and therefore, their data needs are filled by asking the following basic questions:

- How many inquiries are we getting about services?
- Are we getting clients?
- From what area are our clients?
- Are clients entering care once they make contact?
- Are we responsive to clients' needs from first contact forward?

- Is the type of client changing?

In addition to collecting these initial data, program managers must be able to track clients through their services so they can decide how to alter service provision. Important questions include

- Who is in what level of care at what time?
- How does the service fit with their treatment plans?
- Is the program meeting clients' different cultural needs?
- Who is dropping out, and why?
- What service not currently provided is requested most frequently?
- How much money is being spent on a particular service?

Other questions relate to the program manager's administrative functions, including

- What are the case managers doing? What are their caseloads?
- What are the results of internal monitoring?
- Are we reaching the target populations?
- Are clients retained at the appropriate level of care?

Data needs of community policymakers

Community policymakers may be local government officials, members of community coalitions, representatives of local law enforcement agencies, school board members, or other interested community-based stakeholders. Since they are not often directly associated with treatment programs, they may not have a very sophisticated understanding of program goals and may think of outcomes in terms of questions like "Is the client sober or not?" or "Is there less crime?" They tend to be less interested in improved scores on standardized measures of client functioning than in easily defined and observable outcomes that affect the community, principally

- Taxes - Reducing costs to taxpayers in the areas of incarceration, unemployment, and welfare enrollment and reducing costs of case management and substance abuse treatment by substituting a costly treatment with a less expensive one
- Safety - Reducing neighborhood crime and the number of homeless persons loitering in business districts
- Social costs - Increasing the number of substance abusers who are working and improving care for children of substance abusers

Data needs of directors of State alcohol and drug abuse agencies

Directors of State substance abuse agencies value data elements that describe the overall accessibility, quality, and cost of the substance abuse treatment system. In addition, these directors require data to track and contain the growth of Medicaid and public sector behavioral health care expenditures, to put managed care systems in place, and to evaluate the effect of managed care (including the provision of case management) on the delivery of behavioral health care services.

Key data elements that State directors often want to see in evaluation efforts include

- Patterns of service utilization and costs, including the use of public hospital and residential treatment centers
- Numbers of clients working and withdrawing from welfare and Medicaid
- Numbers of clients avoiding prison, reducing child welfare cases and costs, and reducing food stamp usage
- Numbers of appeals and grievances by clients
- Number and characteristics of substance abuse patients accessing other publicly funded social services

Increasingly, State directors of substance abuse agencies are becoming less isolated and are beginning to look for opportunities to exchange data among previously independent departments (e.g., mental health departments, Medicaid offices, and criminal justice offices). Some State agencies share access to statewide data sets. In addition, the movement toward managed behavioral health care has prompted more integration of data between State Medicaid offices and State substance abuse and mental health authorities.

Data needs of third party payers

Third party payers such as insurance companies need data that justify case management as a cost above and beyond the direct costs of treatment services (see Chapter 6). In addition, when case management is used to coordinate care, third party payers want to know whether clients are receiving the right services, at the right level of care, and in the right sequence, and to ensure that clients who are no longer in need are no longer receiving services. To that end, important data elements include

- The severity of the client's illness
- Assignment to levels of care
- Patterns of service utilization
- Use of free self-help or volunteer organization services
- Urinalysis results, use of other drugs, and scores on standardized outcome indicators
- Discharge determinations

Data needs of clients and family members

Clients and family members may serve on advisory or governing boards of local programs or may be involved in family or peer support groups within the community. They may use outcome data, especially results of client satisfaction surveys, to change programs and policies or to choose services and providers. They may be less interested in patterns of service utilization or standardized scores on outcome evaluations than in how the system functions from the user's perspective. In fact, clients might consider a program successful if it is supportive, reliable, and easily accessible, as opposed to "efficient."

Data elements important to clients and family members include

- The availability and accessibility of services

- The freedom of choice (of services and providers) that the system allows
- The use and effectiveness of the appeals and grievance process
- The influence of input from consumers and family members
- Effectiveness of treatment
- Acceptability of treatment among the targeted populations

Specifically, clients seek answers to the questions

- Am I getting the right services, in the right setting?
- Are there systems I can access myself?
- How appropriate is my care?

Management Information Systems

The management information system contains all this information and allows stakeholders to use it. Managed care has provided the behavioral health care field with an example of how to manage far-flung data on clients.

One evaluation task for local programs is determining how to use data already routinely collected by a statewide MIS or managed care company-based MIS, saving the program from duplicating primary data collection. Another important task is to develop or enhance program-level MIS that track data the program needs locally, integrate with other computer-based or paper-based systems, and supply data required by third party payer and governmental bodies. All staff members of a specific program should be stakeholders in the MIS, which increases both system accuracy and the likelihood that a broad array of staff members will use it. If an agency does not have the resources to develop a sophisticated system, it should be able to automate at least a minimum amount of client information through commercially available software.

Local programs that are part of a managed care network undoubtedly will be included in a larger MIS sponsored by the umbrella provider. Providers who are not part of these networks may need to assess their readiness to take on managed care activities by evaluating their current MIS capabilities. Today, it is critical that an MIS be designed with the data requirements of managed care organizations in mind. The following guidelines, adapted from a Federal technical assistance publication, may help a program determine whether its existing MIS is sophisticated enough to support managed care operations. A program's MIS will suffice if it does each of the following:

- Retrieves patient information online or in less than an hour
- Cross-matches client records, use of services, and financial and insurance information
- Permits individual inquiries from managed care organizations
- Produces information that is used by clinicians, supervisors, and managers
- Integrates information from other programs and sites
- Allows client and service information to be reported to all major payers
- Generates patient invoices (CSAT, 1995d)

An existing MIS that can perform all of the above functions will likely support managed care and program demands; if it cannot, the program needs to strengthen deficient areas. Changes and

advancements in data collection and access to patient information must be accompanied by appropriate protections for client confidentiality.

Future Research

Research focused on case management in the substance abuse field is limited and offers many opportunities for local substance abuse programs to make significant contributions to the field. Suggested directions for future research include the following:

- Key ingredients of successful programs, especially for hard-to-reach populations
- Relative cost-effectiveness of particular case management models, including cost outcome results within systems incorporating full parity of substance abuse with other health care, outcome results when a full continuum of care is available to patients, and outcome results associated with use of standardized guidelines for placement, continued stay, and discharge for substance abuse patients
- Improved methodology to investigate research questions in "real world" settings
- Development of brief versions of valid and reliable research outcome instrumentation
- The effect of particular forms of case management on societal costs of substance abuse and its treatment
- Cost shifting among health, behavioral health, criminal justice, and other systems that can be accessed by the target population
- Creative ways to use secondary data sets (such as Medicaid and Medicare) to determine trends and patterns of care
- Research questions from broader sociological or multi-disciplinary perspectives

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Comprehensive Case Management for Substance Abuse Treatment
Treatment Improvement Protocol (TIP) Series 27

Chapter 5 - Case Management for Clients With Special Needs

Case management is an appropriate intervention for substance abusers because they generally have trouble with other aspects of their lives. This is especially true for those clients whose problems or issues can be overwhelming even for non-addicted people. Among these special treatment needs are HIV infection or AIDS, mental illness, chronic and acute health problems, poverty, homelessness, responsibility for parenting young children, social and developmental problems associated with adolescence and advanced age, involvement with illegal activities, physical disabilities, and sexual orientation.

In an ideal world, case managers would be knowledgeable about all those problems and needs. However, understanding the ramifications of even one can be a staggering task. For example, a case manager dealing with a client who has AIDS would need to be conversant in epidemiology, transmission routes, the disease's clinical progression, advances in treatment regimens, financial and legal ramifications, available social services, as well as psychotherapeutic approaches to AIDS patients' grief and fear. Given the many other special needs the case manager confronts, it is apparent that no one individual can be an expert in every area. In the absence of such comprehensive knowledge, several general attitudes and skills provide a basic foundation for the professional delivering case management services to "special needs clients." The case manager serving special needs clients should

- Make every effort to be competent in addressing the special circumstances that affect clients typically referred to a particular substance abuse treatment program
- Understand the range of clients' reactions to the challenges associated with particular special circumstances
- Remain aware of the limits of one's own knowledge and expertise
- Evaluate personal beliefs and biases about clients who have special problems
- Maintain an open attitude toward seeking and accepting assistance on behalf of a client
- Know where additional information on special problems can be accessed

While it is impossible to discuss all the special needs that case managers confront, several occur repeatedly. This information is not intended to be a comprehensive treatment of any of these

areas, but rather an introduction to the issues that most directly relate to the implementation of case management.

Minority Clients

Demographic realities in the United States dictate that case managers will be called on to work with individuals of different gender, color, ethnicity, and sexual orientation. Some will be persons of color; some will be poor, not conversant in English, disadvantaged, and over-represented in many areas of the social services system. Case managers must "respond proactively and reactively to racism, ethnocentrism, anti-Semitism, classism, and sexism . . . ageism and 'ableism'" (Rogers, 1995, p. 61).

There are five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics when cultures interact, (4) incorporating cultural knowledge, and (5) adapting practices to the address of diversity (Cross et al., 1989). According to Rogers, culturally competent case managers have the

- Ability to be self-aware
- Ability to identify differences as an issue
- Ability to accept others
- Ability to see clients as individuals and not just as members of a group
- Willingness to advocate
- Ability to understand culturally specific responses to problems (Rogers, 1995)

Case managers should either speak any foreign languages common in their locale or refer non-English speakers to someone who does. It is also crucial for the case manager to be aware of what may inhibit minorities' participation in the substance abuse treatment continuum. For example, while "accepting one's powerlessness" is a central tenet of 12-Step self-help programs, members of oppressed groups may not accept it, given their own societal powerlessness. The case manager must always be sensitive to such cultural differences and identify recovery resources that are relevant to the individual's values. Some minority group members may be inclined to seek help for a substance abuse problem from sources outside the treatment continuum, such as clergy, group elders, or members of their own social support networks. Others may prefer to be treated in a program that uses principles and treatment approaches specific to their own cultures. Case managers must advocate for culturally appropriate services for their clients.

Clients With HIV Infection and AIDS

The usual functions and activities associated with case management in substance abuse treatment - engagement, helping orient the client to treatment, goal planning, and especially resource acquisition - are made more difficult in dealing with clients who have HIV or AIDS by

- Providers' and other clients' fear of contracting HIV
- The dual stigma of being a person with both a drug abuse problem and HIV
- The progressive and debilitating nature of the disease

- The complex array of medical, especially pharmacological, interventions used to treat HIV
- The onerous financial consequences of the disease and of treatment
- The hopelessness - and lack of motivation for treatment - among the terminally ill

Case managers who provide services to this population must be prepared to work with "a base of diverse resources, enhancement or adaptation of the capabilities of existing resources, or the development of new service programs specifically designed to address [the HIV-infected individual's] needs" (Sonsel et al., 1988, p. 390). The Linkage Program in Worcester, Massachusetts, is typical of this arrangement. It engaged 19 diverse agencies - including drug treatment programs, area churches, AIDS advocacy and support agencies, the city's department of public health and a regional medical center - in a consortium of care for substance abusers who also had HIV infection (McCarthy et al., 1992). The Worcester consortium and other linkage programs demonstrated a positive relationship between the amount of case management services provided and the receipt of drug abuse, health care, and other services (Schlenger et al., 1992).

While one person should assume primary case management responsibility for clients with HIV or AIDS, a team approach is particularly useful in combating the feelings of frustration, abandonment, grief, over-identification with the client, and anger that frequently confront professionals in this setting (Shernoff and Springer, 1992). To avoid staff burnout, providers should avoid designating the same individual as case manager for all clients with AIDS and HIV infection.

The overwhelming nature of life for a person with two life-threatening conditions - AIDS and addiction - cannot be overstated. The magnitude of even daily tasks holds significant stress for both the client and the case manager. Addicted people with AIDS or HIV need help with physical functioning, interpersonal relationships, adjustment to the treatment program, housing, and practical and psychological adjustment to the two conditions.

Part of the case manager's linking function in working with an HIV-positive client is to educate the network of service providers, including substance abuse treatment staff, to recognize the competing demands of staying sober and dealing with the social and physical sequelae of HIV disease.

Clients With Mental Illness

Almost 40 percent of people with an alcohol disorder meet criteria for a psychiatric disorder, and more than half of those with other drug disorders report symptoms of a psychiatric disorder (Regier et al., 1990). Not unexpectedly, the prevalence of coexisting disorders is significantly higher in treatment populations than in the general population, approaching 80 percent in some studies of substance abuse patients (Khantzian and Treece, 1985; Ross et al., 1988; Kosten and Kleber, 1988). Given those high comorbidity rates, substance abuse treatment staff must be prepared to address the problems of dual-diagnosis clients.

Treatment services for clients with a dual diagnosis are organized in sequential, parallel, or integrated models (CSAT, 1994b). In the integrated model, both disorders are dealt with at the

same time and in the same program. Case management's primary role includes facilitating clients' transition from residential programs to the community, helping them identify and access needed resources, and providing long-term support for their functioning in the community.

In the case of sequential treatment, the case manager helps the client move from either substance abuse to mental health treatment or from mental health to substance abuse treatment. In parallel treatment, the case manager must facilitate communication and service coordination between two agencies whose treatment approaches may be based on different assumptions. Examples of the possible issues the case manager may have to address on behalf of a client in mental health treatment programs include the following:

- Bias against substance abusers affects the provision of mental health services
- Many inpatient facilities establish an arbitrary minimum number of days of sobriety for their clients
- Some service providers will not accept clients who are on medication, including methadone

Conversely, issues in substance abuse treatment programs that might be counterproductive to mental health treatment include

- Treatment approaches may rely on insight and introspection that some mental health clients are intrinsically incapable of achieving
- The approach used in substance abuse treatment may be too confrontational
- The treatment program and other clients may reject clients taking psychotropic medication

Many of the special case management issues for clients with mental illness center on the client's use of prescription drugs to stabilize mood and reduce the negative effects of the mental disorder. Some substance abuse treatment providers oppose the use of any psychotropic drugs, fearing that they will interfere with the recovery process and become a new source of chemical dependency or that the prescribing physician is not adequately aware of the client's problems with addiction. Some treatment programs unwittingly precipitate a client's relapse by requiring the client to stop taking all medications as a condition of acceptance to a treatment program. Participants in 12-Step meetings may pressure clients to be free of the "crutch" of prescription drug use.

As substance abuse treatment providers become familiar with prescribed neuroleptic drugs, they are more likely to accept the medical management of the client's illness and communicate more with the professionals providing the client's medical care. To manage client symptoms and behaviors, anticipate problems, and reinforce the medical management of the client, all staff who work with dual-diagnosis clients need some knowledge of the benefits of commonly prescribed drugs, their potential side effects, actual abuse potential, and their interactions with other drugs.

Aftercare tends to be long-term for clients with mental illness because of the continuing possibility that the client will stop taking medications when he begins to feel more stable and then take illicit drugs to cope with the re-emergent symptoms of mental illness. 12-Step programs such as Double Jeopardy, Double Trouble, and Dual Recovery Anonymous designed specifically for people with mental health and substance abuse problems can be valuable sources of support.

While case managers may not be experts in the treatment of any one of these disorders, it is vital that they know enough to work with the client in identifying her needs and be able to translate and coordinate those needs with the two types of treatment.

Homeless Clients

Alcoholism rates among the nation's homeless are estimated to be as much as two to four times the levels for individuals of the same gender in the general population. Besides alcohol, the substances most frequently used by homeless people are marijuana, cocaine, and crack cocaine (National Institute on Alcohol Abuse and Alcoholism, 1989). Crack use in particular has increased in the last 10 years, primarily among younger homeless people (Crystal, 1982). Numerous efforts at engaging homeless individuals in substance abuse treatment have been undertaken, many involving case management as a central component (Braucht et al., 1995; Conrad et al., 1993; Sosin et al., 1995; Stahler et al., 1995).

The need for case management with this population is obvious. Clients need suitable short- and long-term housing; many have mental disorders. Homeless individuals frequently suffer from significant health problems secondary to their lifestyle, including tuberculosis, HIV, and AIDS. Unemployment is high. This constellation of tangible needs can best be addressed by one individual at the interface between the streets and social service agencies.

A case manager always begins by working on issues the client feels are most pressing, and the need for stable shelter may not be at the top of the client's list. Many homeless people feel safer and more comfortable on the streets than in a shelter because the streets are familiar to them and because they have established routines and a network of people to watch out for them. While this setting is hardly ideal, it may be one in which the client can function well enough to benefit from treatment. However, some programs may claim they cannot help homeless individuals until their other life problems are solved, requiring the case manager to advocate on the client's behalf (Sosin et al., 1994).

The case manager's rapport-building skills are critical to break through the many defensive behaviors and protective attitudes that clients develop to survive in shelters and on the streets. These behaviors - looking tough, acting with bravado, wariness of social services, maintaining a hard exterior, and letting go of social graces - make homeless clients difficult to engage and interfere with their ability to succeed in treatment or maintain stable housing. One solution to this difficulty in engaging homeless clients is through the use of *peer case managers*: homeless individuals who are in recovery themselves and are based in shelter care facilities. In one such setting, peer case managers proved to be as successful as degreed professionals or an intensive residential treatment program in assisting homeless individuals in the areas of substance use, housing stability, employment, and psychological functioning (Stahler et al., 1995). In addition, clients were more satisfied with the services provided by the peer case managers than by the degreed professional case managers. This finding may be explained by clients' beliefs that case managers who have experienced homelessness first-hand are more likely to provide needed services.

To meet their linking and advocacy responsibilities, case managers must recognize that some services generally available to substance abusers are not available to homeless people and that new services may need to be created to fill those gaps. For example, Louisville's Project Connect used case management to help homeless alcoholic and drug abusing men move from a sobering-up shelter (the pretreatment phase of the treatment continuum) through a vocational program at the exit point of treatment (Bonham et al., 1990). Another substance abuse program at the Coatesville Veterans' Affairs (VA) Medical Center picks up homeless veterans at local shelters, takes them in vans to the VA for day treatment, feeds them, and takes them back to the shelter. This has helped to keep veterans engaged in treatment as they await placement in a VA domicile or other housing arrangement. The Department of Veterans' Affairs conducts stand-downs in its homeless program, during which veterans temporarily housed in tents receive medical services and are assessed for treatment needs. They are brought into residential care for treatment as needed.

The delivery of social services is complicated by the fact that homeless clients usually are turned out of shelters from 9:00 a.m. until 4:00 p.m. The client's social network during these hours consists of other people, often not sober, who are also out of the shelter. Providers may find it useful to provide a day room with snacks and a television where clients can stay during the day or some sort of day work where clients can earn a few dollars. Case finding can be accomplished by mobile case management teams who seek out homeless substance abusers in shelters and other areas where they sleep and congregate (Rife et al., 1991).

Women With Substance Abuse Problems

Case-finding is an especially important case management activity with female substance abusers, who seem to follow a different path to treatment than males. Because women are often referred by other service providers (Beckman and Amaro, 1986), case managers affiliated with substance abuse treatment programs must help their counterparts in other social service agencies identify women in need of treatment. Women with children are likely to be involved in numerous child-related services; women who have been victims of domestic violence present for services at battered women shelters; other women may appear at mental health centers and women's health centers. A significant number of women clients have suffered physical, verbal, psychological, or sexual mistreatment (Miller and Rollnick, 1991; Mondanaro et al., 1982), and many who present for treatment live in an unsafe environment.

Once identified, women with substance abuse problems may be difficult to engage in treatment. Society judges substance-abusing women more harshly than male substance abusers. A woman's substance abuse problem is likely to have progressed significantly before being identified, and treatment may be complicated by factors like psychological functioning, situational realities, and systemic barriers (Wildwind, 1984). Other issues such as sexual abuse, victimization, and emotional dependency are frequently associated with women who have substance abuse problems (Markoff and Cawley, 1996). Transportation is a common barrier, especially in primary outpatient and aftercare treatment.

Women substance abusers who have children confront these problems and more when considering treatment. A mother's decision to enter treatment means the case manager must

either identify a program that will take both the woman and her children or assist the woman in finding appropriate child care. These mothers may avoid treatment out of guilt and shame for the activities in which they have engaged to acquire drugs and the situations in which they have placed their children. Compounding a mother's shame is the fear that authorities will take her children away from her. As a result, an assessment of such a mother's needs is complicated by the fact that she is likely to lie to the case manager about her addiction and the way her family lives.

The basic functions and tenets of case management are well suited to improving retention and outcomes for women in treatment. There is evidence that women in particular do not adequately focus on their substance use and recovery until their needs for such resources as housing, food, medical care, and personal safety are adequately addressed (Hepburn, 1990). Case managers should assist female clients in developing a safety plan setting out well-defined steps to take should she fear, or be subjected to, violence. It is imperative to determine if women are living in a safe environment. Women who have children are even more extensively involved, or need to be, with community resources, including the school system, pediatric physicians, and children's protective services if their substance use has resulted in neglect or abuse. Case managers are responsible for facilitating the acquisition of these resources as their clients more through the treatment continuum.

A woman's involvement with community resources frequently places the case manager in a position to advocate for her needs. Advocacy means securing resources not only outside the treatment program, but also within the program, especially if the program primarily treats male clients (Brindis and Theidon, 1997). Advocacy not only improves the woman's acquisition of needed resources, but also empowers her to become more assertive on her own behalf and builds a closer relationship with the case manager. Advocacy cannot, however, stop the case manager from fulfilling her legal obligation to report child abuse or neglect.

Two excellent sources of information on the role that case management plays in the treatment of women substance abusers are *Pregnant, Substance-Using Women* (CSAT, 1993) and *Case Management in Substance Abuse Treatment: Improving Client Outcomes* (Sullivan et al., 1992).

Adolescent Substance Abusers

Substance use and dependence are significant problems among adolescents in the United States. Some substance use is due to a developmental tendency to experiment, results in few consequences, and abates with maturity. However, a number of adolescents progress to the point of substance abuse or dependence. Because of the problems associated with abuse and dependence these adolescents are frequently involved with multiple systems, including child welfare, juvenile justice, mental health, and special education (CSAT, 1993).

A case manager is in a unique position to help adolescents and their families interact with those systems. The case manager of a teenager must have a thorough understanding of the developmental issues pertinent to adolescence, an ability to establish rapport with young people, a knowledge of family dynamics, and the ability to provide support and skills training.

The case manager working with adolescents will almost inevitably provide extensive case management services to the entire family as well. Problems such as poverty, child neglect, or parental substance abuse cannot be ignored. Acquiring an entire family as clients has numerous implications for caseload size, available resources, confidentiality, and whether the client is the adolescent, the family, or both. Challenges can arise in numerous contexts, for instance when an adolescent tells the case manager she plans to have an abortion. When State or Federal laws do not provide explicit guidance, the case manager must carefully consider who is actually the client and what are the best interests of the adolescent.

One case management model describes a three-phase approach, providing services during pre-treatment/screening, residential treatment, and continuing care (Godley et al., 1994). The goal of case management services during pre-treatment/intake is to improve access to services, provide initial orientation to the treatment process, and begin skills training. Case management for clients in residential programs links the client to needed services outside the residential facility and ensures a coordinated response by multiple agencies involved in an adolescent's life. During aftercare, the professional implementing case management continues the linkage and monitoring process and provides booster relapse prevention skills training with the goal of decreasing the likelihood of relapse or interrupting a relapse episode.

Family engagement in transition and aftercare activities is paramount for the adolescent juvenile justice client. The transition work with the family needs to begin before the end of the primary treatment episode, and preferably occurs throughout the treatment episode.

Clients in Criminal Justice Settings

The number of substance abusers in the criminal justice system is staggering. The Drug Use Forecasting Project, which tested arrestees in 26 major U.S. cities for illicit drug use, found positive results ranging from 48 percent to 80 percent. In one jurisdiction, 80 percent of all women arrested tested positive for at least one illicit drug. The Bureau of Justice Statistics (U.S. Department of Justice, 1991) reported that 54 percent of State prisoners reported drug use at the time of the offense, and 52 percent reported use during the previous month.

Case management for substance abuse clients in the criminal justice system evolved in a unique fashion, bringing together two complex systems with different goals and philosophies. While the criminal justice system is interested in the rehabilitation of offenders, its main focus is on public safety, which is maintained with punishment and legal sanctions. Likewise, while the substance abuse treatment system supports public safety goals, its primary mission is to change individual behaviors. These goals are not mutually exclusive; in fact, experience has demonstrated that integrating the techniques of these two systems can have a powerful effect on reducing the drug use and criminal activity of drug-involved offenders. Because participation in substance abuse treatment and other social services is often mandated, case managers have the opportunity to engage clients over a longer period of time and may be more likely to effect successful change.

Integrating the two systems requires some effort, however. The need to establish and maintain a therapeutic relationship with clients while integrating the sanction and control obligations of the

criminal justice system poses particular challenges. Ambiguities about the case manager's role in client supervision and confidentiality considerations surface frequently.

The criminal justice system is fragmented into numerous components through which offenders may be assigned. In most jurisdictions, supervision can be provided for certain pretrial offenders who have not yet gone to trial. In other jurisdictions, such offenders may be given the option of diversion, in which successful completion of certain activities will avoid a conviction. Convicted offenders may be sentenced to county jails, state prisons, or probation; probation can include halfway house supervision, intensive probation, or electronic monitoring. Released offenders may be on parole or some other sort of post-incarceration supervision; in some jurisdictions probation sentences may follow sentences of incarceration. Linkages between prison and probation, or between county jails and community-based supervision, may be weak; databases are often not connected; and entities often report to different management structures. For example, probation offices are part of the court system in some jurisdictions, the corrections department in others. Case management efforts are critical to ensuring continuity when offenders move from one supervision level to the next, or between one status or location and another. Managing offenders who are changing status within this system while they are participating in substance abuse treatment services (both inside institutions and in the community) is exponentially more complicated.

Case management with offender populations may be implemented at any point in the criminal justice continuum. Case management can assist offenders in securing resources that are not only vital to their recovery and overall well-being, but also required by their deferred sentencing or probation. Establishing appropriate housing that will facilitate sobriety and helping the offender develop job-seeking skills are but two of the specific activities that may form the basis of the case management relationship. Offenders incarcerated in State and local correctional facilities frequently need assistance in managing their lives as they reenter the larger community. Institutional life is highly regimented, presenting special problems when offenders are released. In working with paroled individuals, the case manager must recognize that prison life encourages behaviors that are not appropriate on the outside. Parolees who have been imprisoned longer than a year may require more time in a semi-structured setting (for example, a halfway house) in order to make the transition from institution to community.

The case manager should address the needs of clients released from institutions in order of importance. The first priority is immediate stability, which can be facilitated by safe housing, access to either primary substance abuse treatment or aftercare, and social networks that facilitate positive behavior. Second, the case manager should either provide or make referral to sources of skills training, since individuals who have served lengthy sentences will likely need either habilitation or rehabilitation training in the areas of job searches, interactions with non-offender social groups, and problem-solving strategies. Third, the case manager should train or find training in setting and accomplishing short- and long-term goals. Incarceration often leads offenders to believe that the locus for control of their lives lies totally with other persons or institutions. While goal-setting is important to any client group, it is particularly important to clients who have had most basic needs provided for them. Ideally, the case manager will begin providing these services several weeks or months before a scheduled release, then follow the

offender into the community. Lastly, the case manager can advocate for the offender both in the treatment environment and the criminal justice system.

In order to maximize effectiveness, several configurations of case management functions have been attempted, including:

Case management provided by the justice system. Justice system case managers are assigned caseloads at specific stages of the system, such as probation or parole. An advantage of this model is that justice system officials are invested in the process because their staff members are implementing it and reporting back to them. Major disadvantages are the expense and the fact that there may be conflicts between the philosophies and goals of the substance abuse and criminal justice systems. Another issue in this model is whether the case manager has actual training in substance abuse treatment approaches and community referral techniques, as opposed to primarily correctional interventions.

Case management provided by a treatment agency. The advantage of a community-based treatment model is that the case manager has a thorough understanding of the substance abuse treatment process. The disadvantages include, again, the expense and the possibilities that the case manager may not be familiar with the criminal justice system or that the treatment agencies may not have the resources for effective case management.

Case management provided by an agency separate from the treatment and justice systems. To reduce costs, a case management coordinator may be employed, with or without a caseload, to conduct intake interviews and supervise paraprofessional staff. The disadvantages of this approach include the addition of another agency to the collaboration.

Case management provided by a coordinator from the justice system who provides consulting services and technical assistance to support existing criminal justice case management. One advantage of this model is system ownership. A coordinator, with or without a caseload, oversees the work of a paraprofessional staff. The coordinator can move the criminal justice system toward a greater awareness of treatment issues by providing technical assistance that demonstrates service coordination.

Case management provided by multidisciplinary groups in the criminal justice system for offender management. This type of group may meet regularly and during crises. This model is the most inexpensive; however, it is the most difficult to successfully operate because no one is assigned overall responsibility for the offender (CSAT, 1995b).

One of the earliest models for case management services in the criminal justice system was created in 1972, when the White House launched a demonstration program known as Treatment Alternatives to Street Crime (TASC) to divert offenders from the criminal justice system into substance abuse treatment. (The program name has since been changed to Treatment Alternatives for Safe Communities.) TASC was initially designed to identify appropriate offenders from the criminal justice system, assess their needs for drug and alcohol treatment, refer them to treatment services, monitor their progress in treatment (including conducting regular and random urinalysis testing), and report that progress back to the criminal justice

system. In order to meet its goals of ensuring continuous treatment for offender clients, increasing treatment retention, improving treatment outcomes, and reducing criminal recidivism, TASC developed a set of core functions or critical elements, including

- Organizational Elements
  - A broad base of support within the justice system with a protocol for continued and effective communication
  - A broad base of support within the treatment system with a protocol for continued and effective communication
  - An independent TASC unit with a designated administrator
  - Policies and procedures for required staff training
  - A data collection system for program management and evaluation
- Operational Elements
  - Agreed-upon offender eligibility criteria
  - Procedures for the identification of eligible offenders that stress early justice and treatment intervention
  - Documented procedures for assessment and referral
  - Documented policies and procedures for random urinalysis and other physical tests
  - Procedures for monitoring offenders, including criteria for success/failure, required frequency of contact, schedule of reporting and notification of termination to the justice system

One helpful development is that recent research has convincingly documented the success of compulsory and coerced treatment for drug involved offenders (Leukenfeld and Tims, 1988; Hubbard et al., 1989; Platt et al., 1988; DeLeon, 1988). TASC clients tend to remain in treatment longer than other criminal justice-referred clients and than voluntary clients; retention in treatment is linked to better treatment outcomes (Toborg et al., 1976).

TASC programs have been successful in identifying a large number of offenders in need of substance abuse services (Cook, 1992). The TASC evaluation conducted in 1976 stated that various programs had achieved success in identifying a large number of offenders qualified for TASC services and that self reports, urinalysis, and referrals from lawyers and judges seemed to increase client flow (Toborg, 1976).

This type of structured case management between the criminal justice and treatment systems has facilitated the traditional goals of each system. Case management benefits the criminal justice system by

- Increasing supervision through drug testing
- Reducing drug use and criminal behavior
- Broadening the range of sanctions available to the criminal justice system
- Providing systems of graduated interventions
- Offering treatment in lieu of or in combination with punishment
- Providing information to the criminal justice system
- Providing a basis for judicial decisionmaking
- Extending the power of the court to influence drug-using behavior

Case management has benefited the treatment system by

- Increasing treatment outreach
- Providing assessments and making appropriate referrals
- Utilizing resources more effectively
- Orienting clients to treatment
- Retaining clients in treatment by utilizing criminal justice leverage
- Supporting treatment compliance
- Facilitating access to additional services
- Providing a framework and structure for managing criminal justice clients (Cook, 1997)

Over the years, the TASC model has been expanded to include offenders throughout the criminal justice system, including mixed offender populations and specific populations such as women or adolescents. Depending on a TASC program's administrative and programmatic structure, the approach to delivery of services may vary. The various models include operation as a separate administrative entity within a court system or functioning as a separate nonprofit organization. Acknowledging the diversity of program design, Cook noted:

"There are clear variations in the management of TASC clients. Some TASC programs are more 'system centered' as an extension of criminal justice system control. Other TASC programs are more 'client centered,' focusing on the rehabilitation needs of the offender. A mix of both seems to produce a healthy symbiosis of criminal justice system leverage, access to treatment, and therapeutic tension" (Cook, 1997).

The TASC model has also been adapted and incorporated in recent innovations such as drug courts, which began managing drug-involved offenders in the late 1980s, and have now been implemented in more than 300 jurisdictions. Judges, prosecutors and defense attorneys, treatment professionals, case managers, and pretrial or probation departments together apply continuous oversight of participants as they undergo substance abuse treatment as part of or in lieu of a criminal sentence. Key components include

- Integration of alcohol and other drug treatment services with justice system case processing
- Prosecution's and defense counsel's promotion of public safety while protecting participants' due process rights, using a nonadversarial approach
- Eligible participants identified early and promptly placed in the program
- Access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
- Frequent alcohol and other drug testing
- Coordinated strategy governing responses to participants' compliance
- Ongoing judicial interaction with each participant
- Measurement through monitoring and evaluation the achievement of program goals and gauge effectiveness; continuing interdisciplinary education promotes effective planning, implementation and operations
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness

See TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT,1996a) for more on drug courts.

While TASC programs have been designed with the interaction of treatment and criminal justice systems in mind, case managers in non-TASC settings must be careful not to encourage or support goals or objectives that place the offender in conflict with expectations of the criminal justice system. The roles of the criminal justice official (usually a probation officer) and the case manager should be defined in advance in agreements forged at the highest levels of both the court and the agency providing services. Typically, the case manager negotiates with the parole or probation officer for sanctions that make clinical sense. Such a relationship affords the case manager the opportunity to educate a representative of the justice system about the value of treatment and case management. An upcoming TIP, *Transition from Incarceration to Community-Based Treatment*, addresses treatment for recently released offenders. It will be available in 1998.

Clients With Physical Disabilities

Chemical dependency is a coexisting problem for many people with physical disabilities (Moore and Polsgrove, 1991). Some 15 to 30 percent of all people with disabilities have a substance abuse problem, more than twice the rate in the general population. Among disabilities, rates of substance abuse are highest among people with traumatic brain injury, spinal cord injury, mental illness, and learning disabilities (Rehabilitation Research and Training Center on Drugs and Disability, 1997). The case manager delivering services to this population must know and understand those conditions as well as blindness, deafness, and chronic disease. Other suggested areas of knowledge are

- The etiology and course of various physical disabilities
- Effective treatment options, both group and individual
- The difference between appropriate disability accommodations and enabling "handicapped" behavior
- How disability acceptance and anger affect substance abuse treatment

Because many social service professionals still assume that people with disabilities are too helpless or too removed from the world to gain access to drugs, the case manager's role may lie chiefly in education - both about physical disabilities and about substance abuse treatment. Clients with disabilities may not recognize their need for substance abuse treatment or may expect to be denied treatment. Once in treatment, they may be misunderstood, or singled out for mobility or communication problems (Rehabilitation Research and Training Center on Drugs and Disability, 1996). The Americans with Disabilities Act (ADA) provides support for treatment programs oriented to this population by mandating that facilities be physically accessible to people with disabilities and that treatment professionals have an understanding of disability issues.

Assessment includes many issues unique to physically disabled persons. The case manager should explore the relationship between the client's disability, substance abuse, and recovery potential. For example, clients who had a significant substance abuse problem before becoming

disabled need different treatment approaches than those who started using to cope with a new disability. An individual with a disability that predates his substance abuse may be obsessively focused on his "disability" and not be aware of the functional limitations imposed by the chemical dependency. Others may have acquired a disability as a direct result of substance abuse, but without "sober" time for understanding the disability they may not be aware of their functional limitations and how their current functioning levels make it difficult to learn or perform certain tasks. Mentors who have disabilities or physical rehabilitation professionals can assist newly disabled individuals in understanding their disability.

Treatment programs may need to be expanded to accommodate clients' disabilities. The case manager may also need to educate other service providers about the needs of people with disabilities. To reach those with physical disabilities, 12-Step groups must be willing to use hearing enhancement equipment (e.g., hearing loops) in meetings and to hold meetings in accessible places. The case manager should become familiar with special equipment in order to help organizations purchase or borrow appropriate resources as required under the ADA.

The person in a wheelchair who must take medication for chronic pain from an injury may prompt resistance from recovery-oriented self-help groups. Similarly, some vocational programs within a treatment setting require clients to be sober for some time before they can be placed in a training setting. As a result, vocational rehabilitation services, while appropriate, are not available to individuals receiving pharmacotherapy for opiate addiction within those programs that do not consider such people drug-free. A case manager from either the disability field or the substance abuse field should educate members of other disciplines on how to structure treatment appropriately. The Center for Substance Abuse Treatment is producing a TIP on persons with disabilities who have substance abuse problems, which will be available in late 1998.

Gay, Lesbian, Transgendered, and Bisexual Clients

Gay, lesbian, transgendered, and bisexual cultures are often associated with substance use in general and alcohol use in particular. Findings suggest that both gay men and lesbians are more likely to be involved in the use of alcohol, marijuana, and cocaine than heterosexual members of all age cohorts (McKirnan and Peterson, 1989; Skinner, 1994), with the differences particularly pronounced among younger people. Gay and lesbian clients may also find their sexual partners in areas prevalent with drugs, increasing the risk of contracting the AIDS virus. The prevalence of use, coupled with homophobia, makes the recognition and treatment of substance abuse problems more difficult.

Given the emotionally charged atmosphere that often surrounds sexuality, case managers must be especially aware of their own feelings and beliefs. The link between personal beliefs and interviewing skills is especially important in the assessment of these clients, who may be reluctant to discuss health problems or issues related to sexual practices. The case manager must know the context of the client's life and ideally, the specialized language used to describe sexual practices in the client's community. The interviewer should gather precise information regarding the nature of the individual's sexual practices and number of sexual partners, unless a client is particularly vulnerable, in crisis, or might otherwise see the inquiry as intrusive or inappropriate.

To help gay or lesbian clients gain access to services, the case manager must know more than just an agency's formal stance toward them. Some agencies that are officially accepting are in fact hostile to homosexual clients, or simply are not familiar enough with their special needs to serve them effectively. A case manager should know which 12-Step meetings, clinics, and other resources are available, knowledgeable, and accommodating to the gay and lesbian communities. As with any client, treatment planning includes helping the gay client identify and develop social opportunities that do not involve drugs and alcohol. Advocacy for gay clients includes helping clients seek treatment for injuries and infections sustained through sexual activity and seeing that clients' needs are taken seriously.

Case Management in Rural Areas

The delivery of case management services in rural areas presents unique challenges. Social services may be lacking or so geographically dispersed that effective access and coordination is difficult. In addition, case managers working in rural areas must frequently deal with a culture in which "everyone knows everyone else," from both the client's and the service provider's standpoint.

Given the scarcity of resources, agencies, and specialty services, the professional in this setting is more likely to be a generalist. Case management is more likely to provide both service and service coordination. The substance abuse case manager must be a tireless source of information and education about substance abuse problems, not just for the client, but for the community as well. Perhaps the most difficult function of the case manager in a rural setting is advocacy. In a close-knit environment, advocating for a client may mean challenging the decisions of other service providers. On the other hand, the professional's close relationships with those providers may benefit the client.

Case management in a rural setting can take one of several forms. Telecommunication and video-conferencing practice models have been used to allow clients relatively easy access to providers and to facilitate providers' communication and recordkeeping (Alemi et al., 1992). Where the client lives far away from the program, services may be provided in an intensive manner, for example, daylong sessions with a particular client. A lack of formal services can be mitigated by the use of informal helping networks such as Alcoholics Anonymous. However, in using informal networks, the case manager will have to deal with the unique challenges to confidentiality occasioned by the rural environment.

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Chapter 6 - Funding Case Management in a Managed Care Environment

Managed care is "an organized system of care which attempts to balance access, quality, and cost effectively by using utilization management, intensive case management, provider selection, and cost-containment methods" (CSAT, 1995d). Despite the antipathy that many public sector health care providers feel toward managed care, those providers are actually striving toward the same ends using similar means as managed care organizations (MCOs). Many substance abuse treatment providers have been working within a managed care framework for decades, that is, looking at utilization data and developing a continuum of care. Substance abuse treatment providers, particularly those who use case management, have historically recognized the importance of connecting disparate services to meet the needs of clients.

Whatever treatment providers' attitudes toward managed care, they will have to learn to operate within its bounds. More than half the States are currently in the process of adopting some form of managed care to provide behavioral health care services, and more than one-third have received Federal waivers to implement Medicaid managed behavioral health programs, with other waivers planned or pending. Some experts predict that many substance abuse programs, already accustomed to scarcity of resources, will make a smooth transition to a managed care environment. However, many programs, particularly those that operate the least like businesses, may find this an extremely challenging time. The need to be accountable for outcomes, particularly in the face of a tax-conscious public, will undoubtedly increase in the managed care era.

To adapt to the world of managed care, treatment programs must assess how their services are currently delivered and identify which elements should be preserved and which should be modified. They also must have a firm grasp on how changes in Federal and State reforms will affect their current and future funding mechanisms.

Funding Case Management in a Managed Care World

Despite the promise of case management as an important adjunct to substance abuse services, it will not survive without empirical data that support its efficacy. Key decisionmakers must believe that case management is an integral component of treatment service before they will incorporate it into the funding structure. This is especially true of States choosing to offer services through managed Medicaid HMOs. It is also true for people who receive services through Medicare HMOs. (See Chapter 4 for a discussion of program evaluation and measuring outcomes.)

Controlling costs while providing care offers program administrators and case managers an opportunity to demonstrate case management's utility to a newly engaged managed care company. For example, clients with long-term or chronic conditions may be required to move from residential facilities to the community before some treatment providers believe they are ready. In this scenario, case management can prove its value by providing the clients with wraparound or supportive services to aid in a successful transition. As another example, outreach case management can help in the area of relapse prevention and aftercare and thus avert the need for high-cost services like inpatient treatment.

Managed care tools - clinical pathways, standardized assessments, and treatment protocols - can work well in a case management context. The challenge then lies in tailoring services to the unique needs of each consumer and avoiding "cookie cutter" services. Use of these tools can increase case management's attractiveness to program administrators who operate in capitated or other forms of shared-risk environments.

The true test is to develop a comprehensive case management system within a managed care framework with the inherent flexibility and resources necessary to eventually show tangible savings. Only then will an MCO be able to clearly justify case management as a reimbursable service.

Who Decides?

The decision to include case management in the array of treatment services usually rests with a primary funding source or at the program level. As many traditional public sector providers overhaul their delivery systems to participate in managed care, they must recognize the importance of case management as a key element of effective treatment and communicate that to the funding source. If the primary source of funding (usually a State agency) expects or requires specific outcomes that go beyond sobriety or cost containment, then a program administrator must develop ways to measure those outcomes.

To undertake scientifically valid outcomes studies is beyond the reach of most treatment programs. Providers can, however, increase the chances of having case management activities reimbursed if they measure everything that helps the client, such as consumer-run support groups, drop-in centers, or "Compeer" programs, in which volunteers help clients maintain sobriety and manage other aspects of their lives. Keeping good records will allow managed care companies to determine exactly what's being provided - and what constitutes case management.

Funding Models

The multiple players involved in funding public substance abuse treatment have posed complex and ongoing problems for program administrators. Each funding stream has its own eligibility rules, service conditions, and reporting requirements, which frequently differ from those of other agencies supporting a program's operations. Case management services are no exception and have traditionally been funded through a variety of sources as well. These include

- Block grants from Federal agencies

- Medicaid, which included options that allow for non-medical services (e.g., the Medicaid Rehabilitation Option)
- Medicare and Supplemental Security Income (SSI) for disabled clients
- Migrant health funds
- Private foundations and funds, such as United Way
- State and/or local tax dollars
- Private insurance

Far too often, the disparate mandates of these funders have exacerbated system and service fragmentation. Integration of funding streams has emerged as a strategy to meld services and provide continuity of care. Some States, in fact, have used Medicaid managed care initiatives as the catalyst for blending funding streams, particularly in full capitation models.

As States gain more freedom to allocate Medicaid dollars as they see fit, the prospect of increased flexibility in services offered at the program level improves. Programs that can account for funds received in terms of positive client outcomes will be better able to structure their service mix in response to clients' specific needs rather than to the dictates of funding agencies removed from the service delivery level.

Managed care is frequently used as a vehicle for integrating funding streams and for fostering collaboration among health care providers. For example, many managed care organizations establish (or will only contract with) integrated provider networks that

- Offer a full range of services
- Extend coverage over a wider geographical or population area (thus increasing the number of potential enrollees and sharing the financial risk among more providers)
- Maximize efficiencies in areas like management information systems

When providers are organized in such a manner, administrative service organizations are engaged to handle a wide range of business duties for the network.

Blended funding approaches, especially those that give providers the necessary freedom to make clinical decisions while still holding them fiscally accountable, can preserve and support the case management function as an integral facet of modern substance abuse treatment. Capitation or enrollment rates based on genuine costs associated with providing treatment and "stop-loss" clauses that cover such contingencies as reimbursement for longer or more intensive treatment than anticipated may help satisfy the providers' desire for flexibility and the payer's demand for fiscal responsibility.

Substance abuse treatment services are treated in different ways depending on which overarching health care delivery model is implemented by the State or by the managed care organization(s) contracted to provide behavioral healthcare. The two models currently prevailing are the *carve-in* model and the *carve-out* model.

Carve-in models

The *carve-in* model integrates physical (e.g., traditional medical services) and behavioral (e.g., mental health and substance abuse services) health care and is often the model chosen to manage a State's Medicaid population. Although the purchaser of services may elect a carve-in approach, frequently the MCO may elect to carve out behavioral health care by contracts with managed care organizations. This is because behavioral health care tends to be the most expensive cost center of treatment within an integrated, managed care model of treatment. The carve-in model generally appeals to providers because many individuals with mental illness and substance abuse problems also have serious physical health problems. Integrating the two also underscores the notion that since body and brain are part of the same system, mental illness and substance abuse are bona fide health problems.

However, in such a model, case management is often administrative in nature and involves clinical oversight and activities such as utilization review and prior authorization procedures. The primary care physician functions as the case manager or gatekeeper who assesses the range of services the client needs and, ideally, refers him to network providers who offer specialty services. This happens when the physician is ill-equipped to provide the often labor-intensive, client-specific case management functions needed to successfully manage the client/member.

This model for behavioral health care has two major drawbacks. First, primary care physicians may underdiagnose substance abuse problems, especially in populations such as women (in whom depression is often diagnosed but seldom tied to substance abuse) and the elderly. Lack of knowledge or the desire to hold down costs also may lead to underutilization of services, with consumers denied access to needed care.

Second, since the course and overall treatment costs of behavioral health problems are less predictable than many physical health problems, the ability to establish firm enrollment or capitated rates is difficult. If rates are too low, the problem of inadequately treating or excluding those most in need of costly or long-term care (e.g., clients needing residential treatment) becomes a legitimate concern. When services are subcontracted, *skimming* may become a problem. In this situation, the opportunity exists to cost-shift "difficult" clients to subcontractors who receive only a percentage of the capitated rate. Not only are funds insufficient to provide proper treatment when this happens, but the subcontracting provider's resources are strained to the maximum.

Carve-out models

In *carve-out* arrangements, behavioral health care is considered distinct from other physical problems and is handled either as a separate contract or is intentionally excluded from a managed care plan. If behavioral health care is carved out and handled as a separate managed care account, it is possible to develop capitation or enrollment fees specifically tailored to this population. Carve-outs also provide States with a mechanism to monitor and control the use of substance abuse or mental health funds and some assurance that those problems are being addressed. Ideally, carve-out managed care organizations will have expertise in substance abuse services or will work jointly with providers who possess that expertise. In all cases, State

officials must develop specific contract language to carefully define their responsibilities (CSAT's Technical Assistance Publication *Purchasing Managed Care Services for Alcohol and Other Drug Treatment* offers suggestions for assessing managed care approaches and structuring effective contracts for managed care services.)

Case management in a carve-out model is likely to remain a service function, particularly if the responsibility for behavioral health care is delegated to the public sector. Given the trends in behavioral health care, the public sector might be advised to learn from the example of the proprietary, more precise matching of clients and service packages through management information capabilities, some aspects of utilization review procedures, and the development of clinical pathways. These efforts also help providers use their resources wisely and ensure that appropriate and cost-effective services are available to individual consumers. Unfortunately, this method lacks integration with the physical medicine side of treatment, which can lead to ineffective case management and duplication of services by the behavioral health provider and the primary care physician.

Preparing a Program for Managed Care

To adjust their current operations to meet new demands, programs need to assess their systems, appraise their readiness to operate in a managed care environment, and position themselves and their case management services in a competitive market by identifying market niches and preparing for increased staff licensing and accreditation.

Systems Assessment

As discussed in Chapter 1, case management assumes different forms depending on its setting and organizational context. Before integrating with managed care, program directors and administrators need to understand how case management is practiced in their program. Administrators must identify potential buyers of case management services and must stay abreast of plans to integrate Medicaid with public funds and efforts to secure private vendors to manage public behavioral health care services.

Administrators also need to ascertain exactly who their program is serving, the nature and the range of clients' problems, and the gaps between what the program offers and what clients need. They must be able to articulate how these gaps are hindering the successful execution of their programs' mission.

With the blending of systems via managed Medicaid and Medicare, providers are now forced to compete directly with each other. Eventually, all services now delivered by traditional community providers will be delivered within a managed care framework. Currently, many public sector providers of services to people under Medicaid managed care guidelines (for managed care companies) are providing administrative and clinical case management services for a "fixed," "blended," or "bundled" rate. That rate is a small piece of the pie that comprises the total per-member capitation payment the provider receives and usually is not assigned a specific dollar value.

What is the program doing?

As a first step in organizational assessment, administrators must clearly define the case management model(s) being used in the program. At the agency level, community needs and available resources must be reviewed. Often case management services are subsumed under the general category of "the costs of doing business." Under managed care, it is important to know precisely what services are being offered, what they cost, and what outcomes can reasonably be expected. Case management must be scrutinized both as a stand-alone activity and as part of a total package of services potentially available to consumers. The importance of auditing the costs and revenues associated with various services cannot be over-emphasized, particularly if a system is moving toward a capitated or shared-risk paradigm. Case management, whether a direct service or administrative function, must add value and provide cost benefit to justify its inclusion in the total array of services.

Clinical case management must demonstrate direct or indirect benefits above those that consumers can expect from traditional services. The gatekeeping function in administrative-level case management limits the discretion and treatment planning authority of a substance abuse professional. Offsetting this disadvantage, ideally, are two systemwide advantages: reduced costs by denying unnecessary services and by providing support for people in the community so that they do not need more expensive residential or inpatient care, and better clinical decisionmaking. The gatekeepers' decisions are based on established clinical pathways and protocols - the goals of this standardization being improved care as well as lowered costs.

Who is paying for case management?

Reimbursement for the case management aspects of treatment may come from one or all of the following sources:

- Private managed-care organizations (MCOs)
- Fee-for-service clients
- Private payers such as corporate employee assistance programs, foundations, and grant funding
- Volunteer and local sources
- Courts and criminal justice funding
- Social service providers (e.g., child welfare)
- User taxes and State and federally appropriated funds

Providers should understand exactly how these funding streams are integrated or separated, as well as the inherent flexibility in their use. Such knowledge will help design a case management program and will also help in advocacy efforts to shape State policy on funding streams.

How does the program model fit within the system?

It is equally important for providers to understand how case management is defined in their State's managed care contract, if at all. What specific activities are considered case management and are they reimbursable? If they are reimbursable, are there limits on the number of billable units per consumer? Is there a finite pool of funds available on a fee-for-service basis? Given the

melding of clinical and fiscal functions at the provider level, it is also critical to consider who benefits from case management and who does not. What is a reasonable length of time to offer services to a consumer? It is imperative that program staff grapple with these questions to best allocate available resources.

Readiness Review

In some cases, conversion to managed care must be accomplished in as little as six months after the enactment of legislation or by corporate decree, so providers must assess their readiness to make this transition rapidly and effectively.

Tools and surveys can help administrators do a readiness review by providing a clear picture of what models they are using and how they fit in the changing environment. One such tool is the *Managed Healthcare Organizational Readiness Guide and Checklist* reproduced in Appendix C. This and similar tools can help agencies evaluate their current operations within each of the following areas

- Program services and structure
- MIS capacities
- Fiscal/financial structures
- Utilization review capabilities
- Program evaluation and quality management
- Staff development and training needs
- Board and management structure
- Marketing
- Licensure and accreditation (CSAT, 1995d)

Identifying Market Niches

In the managed care environment, programs will have to function as businesses and therefore must position themselves and their case management services in a competitive market (Brokowski and Eaddy, 1994). By focusing on the establishment of a market niche like the treatment of special populations (e.g., drug users, criminal justice clients, older adults, clients with HIV and AIDS), an agency can be a player in the transition to managed care. In addition, issues such as staffing, pricing, and salaries can be revisited within the market framework.

Despite its inefficiencies, the public system of behavioral health has more experience and expertise than private programs do in caring for the most seriously disabled populations and in providing services that focus on their everyday life problems, such as employment and housing. Since this chronically needy clientele is least likely to be covered by private employer health plans, it offers a natural market niche for public-sector service providers.

Providers who serve Medicaid and Medicare recipients will see an increase in commercial business as a result of managed care contracts but will primarily be paid indirectly. MCOs will become the main source of revenue for the providers, as opposed to the local or state government. Medicaid and Medicare revenues will flow from the government to the managed

care company to the service provider. High-volume providers, who are successful at delivering high-quality, cost-effective services may even find themselves acquired by the managed care company.

State and Federal governments, in anticipation of the changing public sector system, have been disseminating resources to help publicly funded treatment providers survive and compete in a marketplace dominated by managed care organizations. The Federal Government is also currently designing programs and projects via the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP). The National Leadership Institute Coordinating Center (NLICC) will provide resources, technical assistance, and materials to assist public sector providers in making the internal changes necessary to compete.

Licensing and Accreditation

One of the most controversial aspects of case management is the issue of licensing. Many believe that case managers should have earned at least a master's degree. Others argue that some of the best addictions counselors have received their education through overcoming their own substance abuse.

While both viewpoints - and the many in between - are valid, managed care will increasingly require higher levels of education as case management becomes a common ingredient in its mix of services. Case management functions were performed by paraprofessionals in the 1980s and early 1990s. Today, however, credentialing standards of managed care organizations and other providers require that case management be performed by people with master's degrees in social work or education. All case managers may need to earn advanced degrees to perform reimbursable case management in the near future.

Provider profiling and performance reviews of individual practitioners are commonplace in managed care systems. Because data drive so many managed care decisions, any outlier, whether the cost of one consumer's care or the performance level of an organization or professional, is likely to prompt a closer look. It seems likely that, as managed care organizations gain greater influence in the substance abuse world, there will be an increased demand for more professionally trained treatment personnel and for provider organizations to gain accreditation from national organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Rehabilitation Accreditation Commission (CARF), Community Mental Health Services (CMHS), SAMHSA, or the National Committee for Quality Assurance (NCQA).

Future Directions

The profound changes in reimbursement patterns have sent shock waves through the substance abuse treatment field. And change clearly will persist. Payers and those who allocate resources will continue to demand that the efficacy of services be demonstrated. On the programmatic level this will necessitate evaluating each service component and determining how it contributes to overall objectives. Programs must articulate their service expectations and decide what kinds of training and experience a practitioner must have to successfully deliver them.

What is needed now is more research on case management. Several promising lines of research, presented in Chapter 4, suggest that certain forms of case management activities improved client outcomes, resulting in fewer employment problems, increased income, longer treatment retention, and diminished drug use. Other studies focusing on a criminal justice population suggest far-ranging benefits. However, the applicability of those studies to the population outside prison and jail has yet to be established.

This research should be undertaken in a variety of settings and should address issues that demonstrate the efficacy of case management activities. What approaches work best for what populations in which kind of setting? While such questions are typically investigated by university researchers through demonstration projects, the research community must work with community-based programs in this case. It will require hands-on experience to fully understand how case management functions, what benefits it achieves for program clients, and how much it costs to provide this service. Case managers must be able to follow their clients from pretreatment to aftercare to determine if treatment and services have succeeded. Quantifying its benefits is the most compelling argument for case management.

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Appendix B - Practice Dimensions

Referral and service coordination are the two practice dimensions of addiction counseling that involve case management, according to the Addiction Technology Transfer Centers (ATTC). The following list of attributes that help a case manager perform these functions is excerpted from the ATTCs' publication *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 1998). This material also appears as an upcoming Technical Assistance Publication (TAP), Number 21, available through the National Clearinghouse for Alcohol and Drug Information (NCADI) by phone (1-800-729-6686) or online (ncadi.samhsa.gov).

Referral

The process of facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning.

1. *Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community-at-large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs*

Knowledge

a. The mission, function, resources, and quality of services offered by such entities as the following
    - civic groups, community groups, neighborhood organizations; and religious organizations
    - governmental entities
    - health and allied health care systems (managed care)
    - criminal justice systems
    - housing administrations
    - employment and vocational rehabilitation services
    - child care facilities
    - crisis intervention programs
    - abused persons programs

    - mutual and self-help groups
    - cultural enhancement organizations
    - advocacy groups
    - other agencies
b. Community demographics
c. The community's political and cultural systems
d. Criteria for receiving community services, including fee and funding structures
e. How to access community agencies and service providers
f. State and Federal legislative mandates and regulations
g. Confidentiality regulations
h. Service gaps and appropriate ways of advocating for new resources
i. Effective communication styles

Skills

a. Networking and communication
b. Using existing community resource directories including computer databases
c. Advocating for clients
d. Working with others as part of a team

Attitudes

a. Respect for interdisciplinary service delivery
b. Respect for both client needs and agency services
c. Respect for collaboration and cooperation
d. Patience and perseverance

2. *Continuously assess and evaluate referral resources to determine their appropriateness*

Knowledge

a. The needs of the client population served
b. How to access current information on the function, mission, and resources of community service providers
c. How to access current information on referral criteria and accreditation status of community service providers
d. How to access client satisfaction data regarding community service providers

Skills

a. Establishing and nurturing collaborative relationships with key contacts in community service organizations
b. Interpreting and using evaluation and client feedback data
c. Giving feedback to community resources regarding their service delivery

Attitudes

a. Respect for confidentiality regulations
b. Willingness to advocate on behalf of the client

3. *Differentiate between situations in which it is most appropriate for the client to self-refer to a resource and instances requiring counselor referral*

Knowledge

a. Client motivation and ability to initiate and follow through with referrals
b. Factors in determining the optimal time to engage client in referral process
c. Clinical assessment methods
d. Empowerment techniques
e. Crisis intervention methods

Skills

a. Interpreting assessment and treatment planning materials to determine appropriateness of client or counselor referral
b. Assessing the client's readiness to participate in the referral process
c. Educating the client regarding appropriate referral processes
d. Motivating clients to take responsibility for referral and follow-up
e. Applying crisis intervention techniques

Attitudes

a. Respect for the client's ability to initiate and follow-up with referral
b. Willingness to share decision-making power with the client
c. Respect for the goal of positive self-determination
d. Recognition of the counselor's responsibility to carry out client advocacy when needed

4. *Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs*

Knowledge

a. Comprehensive treatment planning
b. Methods of assessing client's progress toward treatment goals
c. How to tailor resources to client treatment needs
d. How to access key resource persons in community service provider network
e. Mission, function, and resources of appropriate community service providers
f. Referral protocols of selected service providers
g. Logistics necessary for client access and follow through with the referral
h. Applicable confidentiality regulations and protocols
i. Factors to consider when determining the appropriate time to engage client in referral process

Skills

a. Using written and verbal communication for successful referrals
b. Using appropriate technology to access, collect, and forward necessary documentation
c. Conforming to all applicable confidentiality regulations and protocols
d. Documenting the referral process accurately
e. Maintaining and nurturing relationships with key contacts in community
f. Maintaining follow-up activity with client

Attitudes

a. Respect for the client and the client's needs
b. Respect for collaboration and cooperation
c. Respect for interdisciplinary, comprehensive approaches to meet client needs

5. *Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow through*

Knowledge

a. How treatment planning and referral relate to the goals of recovery
b. How client defenses, abilities, personal preferences, cultural influences, presentation, and appearance effect referral and follow through
c. Comprehensive referral information and protocols
d. Terminology and structure used in referral settings

Skills

a. Using language and terms the client will easily understand
b. Interpreting the treatment plan and how referral relates to progress
c. Engaging in effective communication related to the referral process
    - negotiating
    - educating
    - personalizing risks and benefits
    - contracting

Attitudes

a. Awareness of personal biases toward referral resources

6. *Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and generally accepted professional standards of care*

Knowledge

a. Mission, function, and resources of the referral agency or professional

b. Protocols and documentation necessary to make referral
c. Pertinent local, State, and Federal confidentiality regulations, applicable client rights and responsibilities, client consent procedures, and other guiding principles for exchange of relevant information
d. Ethical standards of practice related to this exchange of information

Skills

a. Using written and verbal communication for successful referrals
b. Using appropriate technology to access, collect, and forward relevant information needed by the agency or professional
c. Obtaining informed client consent and documentation needed for the exchange of relevant information
d. Reporting relevant information accurately and objectively

Attitudes

a. Commitment to professionalism
b. Respect for the importance of confidentiality regulations and professional standards
c. Appreciation for the need to exchange relevant information with other professionals

7. *Evaluate the outcome of the referral*

Knowledge

a. Methods of assessing client's progress toward treatment goals
b. Appropriate sources and techniques for evaluating referral outcomes

Skills

a. Using appropriate measurement processes and instruments
b. Collecting objective and subjective data on the referral process

Attitudes

a. Appreciation of the value of the evaluation process
b. Appreciation of the value of inter-agency collaboration
c. Appreciation of the value of interdisciplinary referral

Service Coordination

The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan.

Service coordination, which includes case management and client advocacy, establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs.

Implementing the Treatment Plan

1. Initiate collaboration with referral source

Knowledge

a. How to access and transmit information necessary for referral
b. Missions, functions, and resources of community service network
c. Managed care and other systems affecting the client
d. Eligibility criteria for referral to community service providers
e. Appropriate confidentiality regulations
f. Terminologies appropriate to the referral source

Skills

a. Using appropriate technology to access, collect, summarize, and transmit referral data on client
b. Communicating respect and empathy for cultural and lifestyle differences
c. Demonstrating appropriate written and verbal communication
d. Establishing trust and rapport with colleagues in the community
e. Assessing level and intensity of client care needed

Attitudes

a. Respect for contributions and needs of multiple disciplines to treatment process
b. Confidence in using diverse systems and treatment approaches
c. Open-mindedness to a variety of treatment approaches
d. Willingness to modify or adapt plans

2. *Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information*

Knowledge

a. Methods for obtaining relevant screening, assessment, and initial treatment-planning information
b. How to interpret information for the purpose of service coordination
c. Theory, concepts, and philosophies of screening and assessment tools
d. How to define long- and short-term goals of treatment
e. Biopsychosocial assessment methods

Skills

a. Using accurate, clear, and concise written and verbal communication
b. Interpreting, prioritizing, and using client information
c. Soliciting comprehensive and accurate information from numerous sources including the client
d. Using appropriate technology to document appropriate information

Attitudes

a. Appreciation for all sources and types of data and their possible treatment implications
b. Awareness of personal biases that may impact work with client
c. Respect for client self-assessment and reporting

3. *Confirm the client's eligibility for admission and continued readiness for treatment and change*

Knowledge

a. Philosophies, policies, procedures, and admission protocols for community agencies
b. Eligibility criteria for referral to community service providers
c. Principles for tailoring treatment to client needs
d. Methods of assessing and documenting client change over time
e. Federal and State confidentiality regulations

Skills

a. Working with client to select the most appropriate treatment
b. Accessing available funding resources
c. Using effective communication styles
d. Recognizing, documenting, and communicating client change
e. Involving family and significant others in treatment planning

Attitudes

a. Recognition of the importance of continued support, encouragement, and optimism
b. Willingness to accept the limitations of treatment for some clients
c. Appreciation for the goal of self-determination
d. Recognition of the importance of family and significant others to treatment planning
e. Appreciation of the need for continuing assessment and modifications to the treatment plan

4. *Complete necessary administrative procedures for admission to treatment*

Knowledge

a. Admission criteria and protocols
b. Documentation requirements and confidentiality regulations
c. Appropriate Federal, State, and local regulations related to admission
d. Funding mechanisms, reimbursement protocols, and required documentation

e. Protocols required by managed care organizations

Skills

a. Demonstrating accurate, clear, and concise written and verbal communication
b. Using language the client will easily understand
c. Negotiating with diverse treatment systems
d. Advocating for client services

Attitudes

a. Acceptance of the necessity to deal with bureaucratic systems
b. Recognition of the importance of cooperation
c. Patience and perseverance

5. *Establish accurate treatment and recovery expectations with the client and involved significant others including, but not limited to*
    - nature of services
    - program goals
    - program procedures
    - rules regarding client conduct
    - schedule of treatment activities
    - costs of treatment
    - factors affecting duration of care
    - client rights and responsibilities

Knowledge

a. Functions and resources provided by treatment services and managed care systems
b. Available community services
c. Effective communication styles
d. Client rights and responsibilities
e. Treatment schedule, time frames, discharge criteria, and costs
f. Rules and regulations of the treatment program
g. Role and limitations of significant others in treatment
h. How to apply confidentiality regulations

Skills

a. Demonstrating clear and concise written and verbal communication
b. Establishing appropriate boundaries with client and significant others

Attitudes

a. Respect for the contribution of clients and significant others

6. *Coordinate all treatment activities with services provided to the client by other resources*

Knowledge

a. Methods for determining the client's treatment status
b. Documenting and reporting methods used by community agencies
c. Service reimbursement issues and their impact on the treatment plan
d. Case presentation techniques and protocols
e. Applicable confidentiality regulations
f. Terminology and methods used by community agencies

Skills

a. Delivering case presentations
b. Using appropriate technology to collect and interpret client treatment information from diverse sources
c. Demonstrating accurate, clear, and concise verbal and written communication
d. Participating in interdisciplinary team building
e. Participating in negotiation, advocacy, conflict-resolution, problem solving, and mediation

Attitudes

a. Willingness to collaborate

Consulting

1. *Summarize client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress for purpose of assuring quality of care, gaining feedback, and planning changes in the course of treatment*

Knowledge

a. Methods for assessing client's past and present biopsychosocial status
b. Methods for assessing social systems that may affect the client's progress
c. Methods for continuous assessment and modification of the treatment plan

Skills

a. Demonstrating clear and concise written and verbal communication
b. Synthesizing information and developing modified treatment goals and objectives
c. Soliciting and interpreting feedback related to the treatment plan
d. Prioritizing and documenting relevant client data
e. Observing and identifying problems that might impede progress
f. Soliciting client satisfaction feedback

Attitudes

a. Respect for the personal nature of the information shared by the client and significant others

b. Respect for interdisciplinary work
c. Appreciation for incremental changes
d. Recognition of relapse as an opportunity for positive change

2. *Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders*

Knowledge

a. Functions and unique terminology of related disciplines

Skills

a. Demonstrating accurate, clear, and concise verbal and written communication
b. Participating in interdisciplinary collaboration
c. Interpreting written and verbal data from various sources

Attitudes

a. Comfort in asking questions and providing information across disciplines

3. *Contribute as part of a multidisciplinary treatment team*

Knowledge

a. Roles, responsibilities, and areas of expertise of other team members and disciplines
b. Confidentiality regulations
c. Team dynamics and group process

Skills

a. Demonstrating clear and concise verbal and written communication
b. Participating in problem solving, decision making, mediation, and advocacy
c. Communicating about confidentiality issues
d. Coordinating the client's treatment with representatives of multiple disciplines
e. Participating in team building and group process

Attitudes

a. Interest in cooperation and collaboration with diverse service providers
b. Respect and appreciation for other team members and their disciplines

4. *Apply confidentiality regulations appropriately*

Knowledge

a. Federal, State, and local confidentiality regulations
b. How to apply confidentiality regulations to documentation and sharing of client information
c. Ethical standards related to confidentiality
d. Client rights and responsibilities

Skills

a. Explaining and applying confidentiality regulations
b. Obtaining informed consent
c. Communicating with the client, family and significant others, and with other service providers within the boundaries of existing confidentiality regulations

Attitudes

a. Recognition of the importance of confidentiality regulations
b. Respect for a client's right to privacy

5. *Demonstrate respect and non-judgmental attitudes toward clients in all contacts with community professionals and agencies*

Knowledge

a. Behaviors appropriate to professional collaboration
b. Client rights and responsibilities

Skills

a. Establishing and maintaining non-judgmental, respectful relationships with clients and other service providers
b. Demonstrating clear, concise, accurate communication with other professionals or agencies
c. Applying the confidentiality regulations when communicating with agencies
d. Transferring client information to other service providers in a professional manner

Attitudes

a. Willingness to advocate on behalf of the client
b. Professional concern for the client
c. Commitment to professionalism

Continuing Assessment And Treatment Planning

1. *Maintain ongoing contact with client and involved significant others to ensure adherence to the treatment plan*

Knowledge

a. Social, cultural, and family systems
b. Techniques to engage the client in treatment process
c. Outreach, follow-up, and aftercare techniques
d. Methods for determining the client's goals, treatment plan, and motivational level
e. Assessment mechanisms to measure client's progress toward treatment objectives

Skills

a. Engaging client, family, and significant others in the ongoing treatment process
b. Assessing client progress toward treatment goals
c. Helping the client maintain motivation to change
d. Assessing the comprehension level of the client, family, and significant others
e. Documenting the client's adherence to the treatment plan
f. Recognizing and addressing ambivalence and resistance
g. Implementing follow-up and aftercare protocols

Attitudes

a. Professional concern for the client, the family, and significant others
b. Therapeutic optimism
c. Recognition of relapse as an opportunity for positive change
d. Patience and perseverance

2. *Understand and recognize stages of change and other signs of treatment progress*

Knowledge

a. How to recognize incremental progress toward treatment goals
b. Client's cultural norms, biases, unique characteristics, and preferences for treatment
c. Generally accepted treatment outcome measures
d. Methods for evaluating treatment progress
e. Methods for assessing client's motivation and adherence to treatment plans
f. Theories and principles of the stages of change and recovery

Skills

a. Identifying and documenting change
b. Assessing adherence to treatment plans
c. Applying treatment outcome measures
d. Communicating with people of other cultures
e. Reinforcing positive change

Attitudes

a. Appreciation for cultural issues that impact treatment progress

b. Respect for individual differences
c. Therapeutic optimism

3. *Assess treatment and recovery progress and, in consultation with the client and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment goals*

Knowledge

a. Continuum of care
b. Interviewing techniques
c. Stages in the treatment and recovery process
d. Individual differences in the recovery process
e. Methods for evaluating treatment progress
f. Methods for re-involving the client in the treatment planning process

Skills

a. Participating in conflict resolution, problem solving, and mediation
b. Observing, recognizing, assessing, and documenting client progress
c. Eliciting client perspectives on progress
d. Demonstrating clear and concise written and verbal communication
e. Interviewing individuals, groups, and families
f. Acquiring and prioritizing relevant treatment information
g. Assisting the client in maintaining motivation
h. Maintaining contact with client, referral sources, and significant others

Attitudes

a. Willingness to be flexible
b. Respect for the client's right to self-determination
c. Appreciation of the role significant others play in the recovery process
d. Appreciation of individual differences in the recovery process

4. *Describe and document treatment process, progress, and outcome*

Knowledge

a. Treatment modalities
b. Documentation of process, progress, and outcome
c. Factors affecting client's success in treatment
d. Treatment planning

Skills

a. Demonstrating clear and concise oral and written communication
b. Observing and assessing client progress

c. Engaging client in the treatment process
d. Applying progress and outcome measures

Attitudes

a. Appreciation of the importance of accurate documentation
b. Recognition of the importance of multidisciplinary treatment planning

5. *Use accepted treatment outcome measures*

Knowledge

a. Treatment outcome measures
b. Understand concepts of validity and reliability of outcome measures

Skills

a. Using outcome measures in the treatment planning process

Attitudes

a. Appreciation of the need to measure outcomes

6. *Conduct continuing care, relapse prevention, and discharge planning with the client and involved significant others*

Knowledge

a. Treatment planning process
b. Continuum of care
c. Available social and family systems for continuing care
d. Available community resources for continuing care
e. Signs and symptoms of relapse
f. Relapse prevention strategies
g. Family and social systems theories
h. Discharge planning process

Skills

a. Accessing information from referral sources
b. Demonstrating clear and concise oral and written communication
c. Assessing and documenting treatment progress
d. Participating in confrontation, conflict resolution, and problem solving
e. Collaborating with referral sources
f. Engaging client and significant others in treatment process and continuing care
g. Assisting client to develop a relapse prevention plan

Attitudes

a. Therapeutic optimism
b. Patience and perseverance

7. *Document service coordination activities throughout the continuum of care*

Knowledge

a. Documentation requirements including, but not limited to
    - addiction counseling
    - other disciplines
    - funding sources
    - agencies and service providers
b. Service coordination role in the treatment process

Skills

a. Demonstrating clear and concise written communication
b. Using appropriate technology to report information in an accurate and timely manner within the bounds of confidentiality regulations

Attitudes

a. Acceptance of documentation as an integral part of the treatment process
b. Willingness to use appropriate technology

8. *Apply placement, continued stay, and discharge criteria for each modality on the continuum of care*

Knowledge

a. Treatment planning along the continuum of care
b. Initial and ongoing placement criteria
c. Methods to assess current and ongoing client status
d. Stages of progress associated with treatment modalities
e. Appropriate discharge indicators

Skills

a. Observing and assessing client progress
b. Demonstrating clear and concise written and verbal communication
c. Participating in conflict resolution, problem solving, mediation, and negotiation
d. Tailoring treatment to meet client needs
e. Applying placement, continued stay, and discharge criteria

Attitudes

a. Confidence in client's ability to progress within a continuum of care
b. Appreciation for the fair and objective use of placement, continued stay, and discharge criteria

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Appendix C - Managed Healthcare Organizational Readiness Guide and Checklist: Special Report By James B. Bixler, M.S.

This material first appeared in the Center for Substance Abuse Treatment's Technical Assistance Publication (TAP) 16, *Purchasing Managed Care Services for Alcohol and Other Drug Treatment: Essential Elements and Policy Issues*.

Managed care has become a primary method of organizing and financing healthcare services in the United States, and the delivery of substance abuse treatment services is being significantly affected.

Introduction

A majority of the Fortune 500 companies and more than half of the health maintenance organizations (HMOs) now use managed care arrangements for purchasing substance abuse treatment. Thirty-six State Medicaid programs were using managed care approaches as of early 1993, and another 13 States planned to implement managed care programs by 1994 (U.S. General Accounting Office 1993). Several States have "carved out" substance abuse as well as mental health services for Medicaid recipients.

Publicly funded substance abuse treatment providers must adapt to meet the challenge of managed care, which will expand as the healthcare system changes in response to market forces and as healthcare reform discussions continue in Washington.

Purpose

The guide and checklist have been prepared to assist publicly funded treatment providers become more competitive in a managed care environment. The document is intended especially for use by treatment providers receiving financial support from State funds, Medicaid, and the Federal Substance Abuse Prevention and Treatment Block Grant.

Goals and Objectives

The goal of the checklist is to assist State substance abuse agencies and publicly supported treatment providers to design and implement strategies that will result in these providers being able to participate successfully in managed care programs.

Background

The readiness checklist was developed for the technical assistance program of the Center for Substance Abuse Treatment's Division of State Programs. It built upon the Managed Care Readiness Inventory developed in 1993 by the Oregon community mental health providers and the National Community Mental Healthcare Council.

The checklist was first used at a workshop on managed care issues for project directors, part of the Fall Training Institute of the Pennsylvania Office of Drug and Alcohol Problems. Attendees completed the checklist, and the presenter conducted an interactive discussion about the importance of the issues identified.

After this pilot effort, the checklist was refined during its use in workshops conducted in Oregon, Arkansas, and Tennessee. The guide was added to provide additional information and to help treatment providers use the checklist as a freestanding self-assessment instrument.

Ways To Use the Guide and Checklist

The checklist can be very effective as part of a workshop for treatment providers. Such a workshop would include substantial discussion of strategies for meeting the challenges of healthcare reform, changes in the organization and financing of health care, and the expanded use of managed care.

The guide and checklist can also be used:

- In meetings of regional or local networks of providers
- By providers or networks and their consultants
- By providers as a self-assessment tool

The checklist can be an important part of the development of an organization's strategic plan, as a treatment provider or service network decides how to improve service delivery and position itself for a more successful future.

Why Prepare for Managed Care?

The healthcare system is undergoing very rapid change in response to several fundamental economic forces.

1. Healthcare expenditures consumed 13.2 percent of the Gross Domestic Product (GDP) of the United States in 1991 (Letsch 1993) and rose to more than 14 percent in 1993, which means that almost $1 of every $7 is spent for healthcare services.

2. The growth rate of healthcare expenditures in 1991 was four times the growth rate of the national economy (Letsch 1993).
3. Some experts estimate that national healthcare expenditures will reach 18 to 19 percent of the GDP by 1998.
4. Medicaid expenditures, an important source of payment for substance abuse services, doubled between 1988 and 1992. By 1992, the $199 billion cost of Medicaid equaled the total cost of the Medicare program (Holahan et al. 1993).
5. State Medicaid expenditures have grown until they are second only to the combined State costs of elementary and secondary education (Holahan et al. 1993).

High inflation in healthcare expenditures has led employers and States to seek ways to limit the growth of their insurance premiums, benefit costs, and Medicaid programs.

Substance abuse treatment services and costs increased during the 1980s for many reasons:

- Increased public acceptance of the need for care
- Increased benefit coverages in many health plans
- State activities to include substance abuse services in State Medicaid programs
- A rapid growth in inpatient hospital-based substance abuse and psychiatric units, supported by benefit plans that paid for inpatient treatment and a surplus of hospital beds
- Increases in State and Federal funding of community services, such as the Substance Abuse Prevention and Treatment Block Grant program

Some employers perceived that mental health and substance abuse treatment costs were "out of control" and that service delivery was fragmented. Claire Wilson, in a 1993 article on substance abuse and managed care, wrote: "The skyrocketing utilization and costs of substance abuse treatment during the last 10 years have alarmed corporate benefit managers" (Wilson 1993).

England and Vacarro (1991) identified 21 percent increases in 1990 healthcare expenditures to employers/purchasers as the impetus behind managed care, despite cost containment efforts spanning more than a decade. They said: "Mental health and chemical dependency services, with reported cost increases of up to 60 percent per year, are a prime target for managed care."

These perceptions also were shared by some insurance carriers and HMOs, forcing payers to seek ways to coordinate care and control costs. The result is greater use of HMOs, preferred provider arrangements, increased competition, and - for substance abuse and mental health services - the development of behavioral health managed care organizations (MCOs).

These firms have expanded rapidly in the last 10 years, with the three largest MCOs each reporting more than 10 million persons enrolled, a total of almost 40 million persons for these three firms alone (Oss 1994).

A survey conducted in January 1994 determined that more than 102 million Americans, 45.9 percent of those with health insurance, are enrolled in some type of managed behavioral healthcare program (Oss 1994). The survey did not separate managed care for substance abuse from mental health services; however, almost all behavioral MCOs use an integrated approach. There were:

- 20.0 million in employee assistance programs (EAPs)
- 6.6 million in integrated managed behavioral health/EAPs
- 20.5 million in risk-based behavioral health network programs
- 15.0 million in nonrisk-based network programs
- 37.0 million in stand-alone behavioral health utilization review programs (Oss 1994)

What Is Managed Care and How Is It Changing?

Managed care approaches, such as utilization review and second opinions, have been in place for more than a decade for medical-surgical insured health benefits. Their general purpose is to assure payers that consumers receive the appropriate level of care and that excessive, inappropriate, or unnecessary care is not delivered or reimbursed. These practices arose to regulate the functioning of the fee-for-service system, where financial incentives tend to encourage the delivery of more health services and more expensive procedures.

Another way to define managed care is by the organizational structures used to deliver treatment. Health maintenance organizations are "managed care," because clinical management and financial incentives exist within staff HMOs and independent-practice model HMOs to encourage preventive care and to reduce cost increases.

Feldman and Goldman (1993) indicated that the behavioral health managed care industry "arose as a response to the economic imperatives of spiraling unmanaged mental health and substance abuse costs. In light of escalating costs, payers were essentially faced with two alternatives-cut benefits (which many have done) or manage them so as to control costs and ensure quality."

In addition to concerns about costs, purchasers identified several quality-related problems:

- Overuse of hospitalization
- Purchase of services without any indication of clinical effectiveness-making it difficult to identify good care and good providers
- Incentives in traditional benefit plans to use hospitalization rather than outpatient alternatives
- Fragmented service delivery and the lack of coverage for case management services in traditional indemnity plans (England and Vacarro 1991).

Without a doubt, the industry has grown rapidly. In general, it has gone through three major phases since the mid-1980s.

1. The first generation of MCOs managed access to health care, with a primary focus on utilization review (UR). Access was controlled by limiting benefits and requiring significant co-payments to contain costs. MCOs also introduced such administrative barriers as preadmission certification.
2. The second generation of managed care focused on managing benefits. MCOs added fee-for-service provider networks, selective contracting, and treatment planning to the UR function.
3. The current generation of MCOs focuses on managing care, performing utilization management instead of utilization review-with a greater emphasis on treatment planning, delivery of the most appropriate care in the most appropriate setting, and moving patients through a continuum of services.

Managed care organizations expect development of a fourth-generation product in which they manage outcomes as part of an integrated services system, moving both public and private patients through a full continuum of treatment services (Waxman 1994).

The impact on treatment providers over the last 10 years has been dramatic. Hospitals that deliver substance abuse care have reduced staff and closed units or have integrated their inpatient care for substance abuse within psychiatric units. Many hospitals have expanded ambulatory substance abuse services. Community agencies have scrambled to learn about managed care and to become members of MCO provider panels.

These changes are likely to continue as the managed care industry increases its focus on Medicaid recipients, State and local governments, and services to other public clients.

How Do Managed Care Organizations Select Treatment Providers?

Behavioral health managed care organizations (MCOs) work for self-insured businesses, HMOs, insurance carriers, unions, State Medicaid agencies, and others. Prior to deciding which providers to select, they first listen to their customers.

Some payers will dictate the qualifications of substance abuse treatment providers. These payers may require hospitals for residential care and require licensed professionals for outpatient treatment. Increasingly, MCOs are recommending that less expensive yet well-qualified community providers be included on the "provider panel." This enables MCOs to lower costs and to offer a more complete range of services.

The selection criteria of MCOs cover several areas:

- Access to care and a provider's response time; i.e., the availability of inpatient and residential beds as needed, and access to outpatient services based on:
    - Emergencies: immediate access
    - Urgent services: 1-2 days
    - Routine services: 4-6 days
- Minimal delays for patients transferring from one service to another, particularly within a single provider
- Administrative and clinical responsiveness
- Use of brief, problem-centered clinical approaches rather than long-term rehabilitative approaches
- Positive practice profiles; i.e., providers who are pragmatic, innovative, team-oriented, consumer-oriented, case management-oriented, and outcomes-oriented
- Cultural competence
- Willingness to arrange for related social services as needed, e.g., housing or job placements

What Strategies Should a Treatment Provider Consider?

The specific strategies that a substance abuse provider adopts will depend on the level of readiness of the provider and the State and local managed care environment.

The provider should develop an individualized plan that is specific to the circumstances and locality. The first step can be to complete the readiness checklist and consider potential change strategies within the organization. Providers may find it necessary to make changes in their clinical and management services in order to become more attractive to MCOs and other payers.

Short-range strategies

Short-range strategies could include:

- Strengthening relationships with businesses through relationships with EAPs
- Maximizing Medicaid reimbursements and positioning the provider organization to expand its participation in Medicaid as managed care arrangements are implemented
- Becoming a preferred provider for several managed care organizations

Longer range strategies

Longer range strategies to be considered might include:

- Determining the extent to which the provider organization will address a broad client group by delivering a range of services or by focusing on one or more niche markets, i.e., specialty services for a limited population
- Joining or forming a regionally integrated substance abuse and/or behavioral health service network, which can seek preferred provider and other contracts
- Marketing to primary care medical group practices and multipractice physician groups, which have an increasingly critical "gatekeeper/service manager" role in healthcare reform
- Marketing directly to payers, such as HMOs, insurance carriers, and self-insured businesses
- Integrating fully into the healthcare system by becoming part of a physician-hospital organization or an arm of a large physician group practice.

Use the following checklist [see Exhibits] to assist you in developing your agency's individualized plan for future challenges.

Managed Healthcare Organizational Readiness Checklist

Following is a managed care readiness checklist [see Exhibits] for publicly funded substance abuse treatment service providers, a vital segment of the health services system. The checklist is intended:

1. To identify a program's strengths and weaknesses in specific areas, and
2. To enhance a strategic planning process that will assist your organization to prepare for success in a managed care environment.

Use of the checklist will help treatment providers anticipate the skills that will be needed to prosper in a changing healthcare system.

Use of the checklist cannot substitute for an onsite assessment. However, it is likely to generate

productive thought and discussion.

It is not necessary to have a perfect score to secure a contract with a managed care firm for private or public patients. In general, the better prepared your organization, the more likely it is that you will be selected to provide services.

Twelve areas are assessed:

- Adult services
- Adolescent services
- Service characteristics
- Quality assurance and utilization management
- Managed care and employee assistance program experience
- Management information system
- Staff and staff training
- Organizational relationships
- Board and management
- Marketing
- Fiscal analysis
- Business office

There are survey questions for each area. In addition, there is a summary at the end of the checklist.

Please answer each question using a *whole* number, i.e. 1, 2, 3, 4, or 5. One is the lowest score, while 5 is the highest score. Use the following scale [see Exhibits] for your response.

Summary of Answers

This section allows you to generate a score for each area. Add together the individual response scores for the questions in each of the 12 sections. Then divide the total by the number of questions in that section to generate a composite score for the section. Enter the composite score on the 1 to 5 scale at right.

Summary of Answers

	Total	**Divide By**	**Composite**	**Weakest Position**			**Strongest Position**	
Adult Services Comprehensiveness	_____	6	_____	1	2	3	4	5
Adolescent Services	_____	6	_____	1	2	3	4	5

Comprehensiveness								
Service Characteristics	_____	12	_____	1	2	3	4	5
QA and UM area	_____	10	_____	1	2	3	4	5
Managed Care an EAP area	_____	5	_____	1	2	3	4	5
MIS area	_____	7	_____	1	2	3	4	5
Staff and Training	_____	4	_____	1	2	3	4	5
Organizational Relations	_____	3	_____	1	2	3	4	5
Board and Management	_____	6	_____	1	2	3	4	5
Marketing	_____	6	_____	1	2	3	4	5
Fiscal Analysis	_____	7	_____	1	2	3	4	5
Business Office	_____	3	_____	1	2	3	4	5
All scores	_____	75	_____	1	2	3	4	5

This approach will show you the areas in which your organization is well prepared for managed care participation, the areas in which additional work may be needed, and the areas of relative weakness where immediate remedial activities can be targeted.

It may also be helpful to inspect the variations in the scores among the various persons in your organization who complete the checklist. You may find a range of answers and perceptions on a specific question or within one or two sections. It might be illuminating to note the differences, for instance, between management, board members, and clinical staff.

Common Questions and Answers

There were several common questions asked by treatment providers who attended workshops in which the checklist was used. This part of the guide gives answers to a few of those questions.

QUESTION: *Do I have to pay attention to these managed care issues? I have contracts with the State and revenue from fees, so won't my organization survive intact?*

ANSWER: Economic forces are leading to the use of managed care approaches by almost all payers. If you have secured a "niche market," where it is unlikely that other organizations will compete with you, then you may be in a unique situation where the payers will continue to buy your service. However, organizations that deliver basic outpatient and residential substance abuse care cannot ignore managed care.

QUESTION: *My organization delivers residential treatment. Should I add outpatient services or otherwise diversify?*

ANSWER: Managed care organizations frequently shift services from hospital inpatient to community residential facilities. A second strategy of MCOs is to then shift the location of care from brief residential services to intensive outpatient or outpatient care as quickly as possible. The best strategy would be to offer all needed services and plan to shift the balance between services as referral patterns and MCO practices change.

QUESTION*: What staff qualifications do managed care firms require for outpatient services, and are graduate degrees a necessity?*

ANSWER: There is considerable variation. Staff qualifications are frequently determined by the payer rather than the MCO. Some MCOs require State-licensed practitioners, while others accept all staff working within a licensed or State-approved program.

QUESTION*: How cost competitive is managed care? Will I be asked to accept reimbursement rates below my cost?*

ANSWER: Most MCOs attempt to secure discounted rates. It is important to know your costs and establish a level below which you will not negotiate. It is also important to be aware of the costs and rates of your competitors, in order to be able to judge the marketplace.

QUESTION*: Will managed care require my organization to change our clinical practices?*

ANSWER: As you market your services, carefully consider the types of services that managed care organizations want. Most will favor brief and focused counseling models, with rapid step-down to less intensive levels of care.

You may have to modify your service practices in order to secure and maintain business.

QUESTION*: My staff are concerned about losing clinical control of our services to a gatekeeper or case manager. Is it necessary to give up clinical control if I get a contract?*

ANSWER: It's best to think of working with an MCO as a partnership where you exchange information about clients and determine a plan of treatment together. Most MCOs watch the length of treatment episode very carefully, either through a case manager or by reviewing your organization's practice patterns (based on the analysis of your organization's paid claims).

QUESTION*: We don't do outcome studies. How can I begin to focus on the impact of treatment?*

ANSWER: Implementing a consumer satisfaction survey is a good place to begin. It can provide feedback on access, staff, the most (and least) valuable components of services, and the value of care to clients and family members.

QUESTION*: Will it be necessary to create new alliances, join networks, establish joint ventures, or merge with another organization to be successful?*

ANSWER: It depends on your local situation and your organization's goals. There are many new relationships currently being established to improve the likelihood of doing well as the healthcare system changes. You may find arrangements that strengthen your organization clinically and managerially. No organization should rule out considering these options.

How Can We Design an Action Program for Change?

The information you gained from completing the readiness checklist is a good start. There are several steps in classic organizational planning. The action planning steps are to:

Assess Your Current Position

- Assess your organization's strengths: What do you have going for you, and what should you be sure to maintain and/or expand?
- Assess your organization's limitations: What areas need improvement, and what is your realistic capability to address these areas internally?
- Assess the opportunities emerging in the marketplace: What are the commercial and public managed care developments in your State and locality?
- Assess the competition and other challenges: What threatens your plans, how quickly will you need to implement changes, and what are your competitors planning which will impact on your future?

Develop an Achievable Plan

- Establish clear long-range goals: What changes are needed in the organization's mission and long-range targets, if any?
- Chart 1-2 year objectives: What are the priority actions that will make the greatest difference as you penetrate the managed care market?
- Develop targets: What are the numerical targets and the schedule to be used for each priority action?
- Involve the staff and board: What steps must be approved and accomplished by the various

actors, and what are the resource requirements?
- Consider strategic partnerships: What new organizational relationships will strengthen your ability to reach your objectives, and what scarce skills or resources are essential to success?

Implement the Plan

- Assign the tasks: What are the expectations for all of the key persons and organizational units?
- Coordinate the work: Manage the process and make the needed adjustments in day-to-day activities.

Check Progress and Adjust the Targets

- Review achievements against the objectives: What was accomplished and what were the deviations from the plan?
- Reassess the environment: What has occurred in the business environment, with Medicaid managed care, in healthcare reform, or in your local service system that will impact on your success?
- Change the strategic plan: What better strategies have been identified and how should the plan, targets, or timetable be modified based on your experiences?

Summary and Conclusion

This guide and checklist were developed for the Center for Substance Abuse Treatment (CSAT) to assist States and publicly funded substance abuse treatment providers to succeed in a managed care environment. The objectives are to increase managed care participation by expanding knowledge, assessing readiness through use of the checklist, and encouraging effective action planning.

Remember, the checklist will be helpful but should not be the only tool your organization uses to prepare for managed care participation. Providers should attend workshops, read, share ideas with colleagues, and participate in State association activities.

Treatment providers seeking additional assistance should contact their State authority or CSAT's Quality Assurance and Evaluation Branch within the Division of State Programs.

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[Exhibits]

Figure C-1: Sample Selection Criteria

Figure C-1
Sample Selection Criteria

First Mental Health, an MCO that operates the Medicaid substance abuse and mental health managed care program in Massachusetts as MHMA, Inc., looks for organizations and programs that:

- Are consumer-oriented, e.g., have satisfaction surveys and use the information
- Have no long waiting lists
- Deliver focused treatment, e.g., an average of six outpatient sessions
- Are part of a system that promotes clinical continuity, e.g., a consumer can move from service to service without interruption
- Direct their attention to outcomes, e.g., functional levels and employment
- Have an interest in innovation, with the ability to move rapidly and to be responsive

Managed Care Organizational Readiness Checklist - Scale

No, None, Never	Very Limited, Not Often	Partially, Frequently	Mostly, Regularly	Yes, Fully, Always
1	2	3	4	5

Managed Care Organizational Readiness Checklist

Service Comprehensiveness

For adults, do you deliver: *Please circle the answer...*

1. Centralized screening, assessment, intake, and crisis intervention services?	1	2	3	4	5
2. Comprehensive outpatient services?	1	2	3	4	5
3. Intensive outpatient services, or do you have strong network relationships with providers of such services?	1	2	3	4	5
4. Partial hospitalization/day treatment services, or do you have strong network relationships with providers of such services?	1	2	3	4	5
5. Short-term residential treatment, or do you have strong network relationships with providers of such services?	1	2	3	4	5
6. Inpatient treatment, or do you have strong network relationships with providers of such services?	1	2	3	4	5

For children and adolescents, do you deliver:

7. Centralized screening, assessment, intake, and crisis intervention services?	1	2	3	4	5
8. Outpatient services?	1	2	3	4	5
9. Intensive outpatient services, or do you have strong network relationships with providers of such services?	1	2	3	4	5
10. Partial hospitalization/day treatment services, or do you have strong network relationships with providers of such services?	1	2	3	4	5
11. Short-term residential treatment, or do you have strong network relationships with providers of such services?	1	2	3	4	5

12. Inpatient treatment, or do you have strong network relationships with providers of such services?	1 2 3 4 5
Service Characteristics	*Please circle the answer...*
13. Do you have skilled clinical staff assigned to all aspects of the screening and assessment process, including initial telephone contacts?	1 2 3 4 5
14. Do your services ensure rapid access (1-2 days) to assessment services and initial placement?	1 2 3 4 5
15. Do your services have a brief intervention focus, e.g., six to eight sessions for outpatient care, for most patients?	1 2 3 4 5
16. Do you have internal case management services for focusing on repeating patients and others who have high utilization patterns?	1 2 3 4 5
17. Do you have ensured linkages with primary healthcare providers for needed healthcare?	1 2 3 4 5
18. Do you adapt standard services to meet the needs of special populations, such as mentally ill substance abusers, injecting drug users, and pregnant addicts?	1 2 3 4 5
19. Are service needs constantly reevaluated, and service plans modified, based on patient progress?	1 2 3 4 5
20. Are admission, treatment, and discharge criteria in place and used consistently by staff?	1 2 3 4 5
21. Do your admission, treatment, and discharge criteria take into consideration the practice standards of managed care firms with which you have (or hope to have) contracts?	1 2 3 4 5

22. Do your services ensure rapid linkage to succeeding levels of care?	1 2 3 4 5
23. Do your services emphasize family involvement and use of natural support systems, including self-help groups?	1 2 3 4 5
24. Do your services focus on patient outcomes and satisfaction?	1 2 3 4 5
Quality Assurance (QA) and Utilization Management (UM)	*Please circle the answer...*
25. Do you have QA and UM procedures that have been shared with clinical staff?	1 2 3 4 5
26. Does the staff you have designated to perform the QA/UM function review clinical activities for consistent use of established admission, treatment, and discharge criteria?	1 2 3 4 5
27. Is the information from the QA/UM function received rapidly enough to assist clinicians *during* an episode of care?	1 2 3 4 5
28. Does the QA/UM function include maintaining records of managed care appeals, and suggest strategies for improving relationships and/or modifying service delivery to reduce denials?	1 2 3 4 5
29. Do you have sufficient staff assigned to the QA/UM function?	1 2 3 4 5
30. To what extent is the QA/UM function designed to "stay ahead" of staff from managed care firms by anticipating their concerns?	1 2 3 4 5
31. Do clinicians, clinical supervisors, and management all receive and act on regular QA and UM reports?	1 2 3 4 5

32. Is the QA/UM function tied closely to your management information system?	1 2 3 4 5
33. To what extent is the QA/UM function focused on patient outcomes?	1 2 3 4 5
34. Are patient satisfaction surveys a regular function of QA/UM?	1 2 3 4 5
Managed Care and Employee Assistance Program (EAP) Experience	*Please circle the answer...*
35. Do you have contract(s) with managed care firms or EAPs as a preferred provider?	1 2 3 4 5
36. If yes to #35, are any of your contracts paid on a fee-per-case or a capitation basis?	1 2 3 4 5
37. Do you offer an employee assistance program which includes crisis intervention, assessment and linkage to service, followup to assure receipt of appropriate services, and coordination of benefits?	1 2 3 4 5
38. Does your EAP provide consultation to management on policies and procedures, training to managers and supervisors, assistance with specific cases, employee education and orientation programs, critical incident debriefing, and reporting on utilization and effectiveness?	1 2 3 4 5
39. Has your EAP business increased over the last 2 years?	1 2 3 4 5
Management Information Systems (MIS)	*Please circle the answer...*
40. Do you have an MIS which can retrieve patient information either online or in less than 1 hour?	1 2 3 4 5
41. Does your MIS have integrated functions for client information; service utilization; financial	1 2 3 4 5

information, including payer type by client; and client records?	
42. To what extent does your MIS permit single-source response inquiries from managed care organizations?	1 2 3 4 5
43. To what extent does your MIS produce information that is used by clinicians, supervisors, and management?	1 2 3 4 5
44. To what extent does your MIS integrate information from various programs and sites?	1 2 3 4 5
45. Is your MIS designed so that client and service information can be reported to all major payers?	1 2 3 4 5
46. Does your MIS generate patient invoices?	1 2 3 4 5
Staff and Staff Training	*Please circle the answer...*
47. Do clinical staff accept shared responsibility with case managers from managed care organizations for clinical decisions?	1 2 3 4 5
48. Are staff informed concerning the funding and managed care environment, including managed care criteria for admission and discharge?	1 2 3 4 5
49. Have clinical and supervisory staff resolved concerns about cost, service quality, access, and managed care?	1 2 3 4 5
50. Do you have an ongoing staff training program that includes brief service intervention skills, patient assessment and reassessment, and instructions on how to respond to managed care organizations?	1 2 3 4 5
Organizational Relationships	*Please circle the*

	answer...
51. To what extent have you implemented referral and business arrangements with other behavioral healthcare organizations, e.g., mental health and substance abuse programs?	1 2 3 4 5
52. To what extent have you implemented referral and business arrangements with primary or specialty healthcare organizations, e.g., hospital emergency rooms and physician group practices?	1 2 3 4 5
53. To what extent have you been involved in economic arrangements with other healthcare?	1 2 3 4 5
Board and Management	*Please circle the answer...*
54. Do you have significant experience at contract negotiation and management?	1 2 3 4 5
55. To what extent is the board oriented to service effectiveness and business success?	1 2 3 4 5
56. Are you experienced at strategic planning, modifying plans, and developing contingency plans to meet emerging opportunities and challenges?	1 2 3 4 5
57. How well informed are board members and top management concerning healthcare reform, managed care, financing options, and interorganizational arrangements?	1 2 3 4 5
58. Are mechanisms in place which would allow for prompt shifts in response to business opportunities?	1 2 3 4 5
59. To what extent will the board and management be proactive and entrepreneurial in pursuit of managed care initiatives?	1 2 3 4 5

Marketing	*Please circle the answer...*
60. Do you have marketing plans that target payers, referral sources, and the general public?	1 2 3 4 5
61. Do you have sufficient staff resources assigned to the marketing function?	1 2 3 4 5
62. To what extent does your service line emphasize acute and primary services (rather than long-term, rehabilitative, and wraparound care)?	1 2 3 4 5
63. Have you prepared a managed care capability statement?	1 2 3 4 5
64. To what extent have you made marketing presentations to the large employers in your service area?	1 2 3 4 5
65. Do your costs per episode and lengths of stay compare favorably with the competition?	1 2 3 4 5
Fiscal Analysis	*Please circle the answer...*
66. To what extent is your revenue diversified?	1 2 3 4 5
67. Do you have adequate liquid reserves for at least 2-3 months operating expenses?	1 2 3 4 5
68. Have you accumulated (or can you access) venture capital sufficient to respond to a major business opportunity?	1 2 3 4 5
69. Have you maximized Medicaid revenue?	1 2 3 4 5
70. Does your fiscal system, in combination with the MIS, allow analysis of cost-per-unit of service, cost-per-episode of care, and cost by disability type and	1 2 3 4 5

level of functioning?

71. Can the fiscal staff assist with pricing issues during contract negotiations, especially when capitated contracts are considered?	1 2 3 4 5
72. Can the fiscal staff readily compare actual to anticipated revenue and expense by contract?	1 2 3 4 5
Business Office	*Please circle the answer...*
73. Is the business office experienced at fee-for-service invoicing for Medicaid, preferred provider organization (PPO) contracts, insurance, patient fees, etc.?	1 2 3 4 5
74. Does the business office conduct internal service audits to ensure that documentation of services in patient records can withstand an external audit?	1 2 3 4 5
75. To what extent is the business office's invoicing function integrated into your MIS?	1 2 3 4 5

Figure 1-1: Definitions of Case Management

Figure 1-1
Definitions of Case Management

Case management is

- "planning and coordinating a package of health and social services that is individualized to meet a particular client's needs" (Moore, 1990, p. 444)
- "[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner" (Intagliata, 1981)
- "helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once" (Ballew and Mink, 1996, p. 3)
- "monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after" (Ogborne and Rush, 1983, p. 136)
- "assisting the patient in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external

resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources" (Rapp et al., 1992, p. 83)

- "assess[ing] the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs." (National Association of Social Workers, 1992, p. 5)

Figure 1-2: Models of Case Management

Figure 1-2
Models of Case Management

Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Conducts outreach and case finding	Not usually	Depends on agency mission & structure	Depends on agency mission & structure	Depends on agency mission & structure
Provides assessment and ongoing reassessment	Specific to immediate resource acquisition needs	Strengths-based, applicable to any of client life areas	Broad-based, part of a comprehensive (biopsychosocial) assessment	Broad-based, part of a comprehensive (biopsychosocial) assessment
Assists in goal planning	Generally brief, related to acquiring resources, possibly informal	Client-driven, teaches specific process on how to set goals and objectives, goals may include any of client life areas	Comprehensive, goals may include any of client life areas	Comprehensive, goals may include any of client life areas
Makes referral to needed resources	Case manager may initiate contact or have client make contact on own	As negotiated with client, may contact resource, accompany client, or client may contact on own	As needed, many resources integrated into broad package of case management services	As negotiated with client, may contact resource, accompany client, or client may contact on own

Monitors referrals	Follow-up checks made	Close involvement in ongoing relationship between client and resource	Close involvement in ongoing relationship between client and resource	Close involvement in ongoing relationship between client and resource
Provides therapeutic services beyond resource acquisition, e.g., therapy, skills-teaching	Referral to other sources for these services if requested	Usually limited to responding to client questions about treatment issues, education about how to identify strengths and about self-help resources	Provides many services within unified package of treatment/case management services	Provision of therapeutic activities central to the model
Helps develop informal support systems	No	Development of informal resources - neighbors, church, family - a key principle of the model	Through implementation of drop-in centers and shelters	Emphasis on family and self-help support through therapeutic activities
Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/Rehabilitation**
Responds to crisis	Responds to crises related to resource needs such as housing	Responds to crises related to both resource needs and mental health concerns; active in stabilization and then referral	Responds to crises related to both resource needs and mental health concerns; active in stabilization and then referral	Responds to crises related to both resource needs and mental health concerns; will stabilize crisis situation and provide further therapeutic intervention
Engages in advocacy on behalf of	Usually only at level of line staff	Assertive advocacy, will pursue multiple	Assertive advocacy, will pursue multiple	Assertive advocacy, will pursue multiple administrative levels

individual client		administrative levels within agency	administrative levels within agency	within agency
Engages advocacy in support of resource development	Not usually	Usually in context of specific client needs	Either advocates for needed resources or may create resources as part of case management services	Usually in context of specific client needs
Provides direct services related to resource acquisition as part of case management, e.g., drop-in center, employment counseling	Referral to resources that provide direct services	Provides services crucial to preparing client for resource acquisition activities, e.g., role playing, accompanying client to interviews	Provides many direct services within unified package of treatment/case management	Provides services that are part of rehabilitation services plan; skill-teaching
Appropriate for the following substance abuse populations				
	Injectable drug users; HIV positive and at-risk substance abusers	Male crack cocaine users; female polysubstance abusers	Chronic public inebriates; parolees with substance abuse problems; dually diagnosed clients	Dually diagnosed clients; female polysubstance abusers

Figure 3-1: Characteristics of Three Interagency Models

Figure 3-1 Characteristics of the Three Interagency Models
Single Agency

Characteristics

- Small grassroots agency or major provider of services for a single problem or to a single population (may be "the only game in town")
- Tends to control a niche in the social service market by default (other agencies are not interested or refuse to serve clients), history, design, or funding mandate
- Often developed in response to an "acute" situation and implemented quickly
- Less focused on organizational process than other case management models; more focused on client-related tasks
- Interagency case management services built on informal agreements
- Case manager hired by and accountable solely to the single agency

Positive Features

- Responds to crises quickly
- Tends toward more cohesive or homogeneous values than other models
- Tends to have single point of access to substance abuse treatment or other services for clients
- Agency maintains sole control over implementation and coordination of case management program
- Clients relate to a single individual concerning all problems
- Often can respond more flexibly to individual client needs
- Has the opportunity to exercise a broad range of skills
- Is self-determining and self-accountable (monitors its own services)

Negative Features

- Less control over social environment (e.g., policies and funding) and accessibility to services
- Less influence over broad policies affecting case management services
- Without a broad constituency and widespread community support, more vulnerable when funding wanes or ends
- More responsibility or burden on front-line case management staff to establish connections with other community agencies
- Case manager may feel especially burdened or taxed by having sole responsibility for client
- Can require considerable training to equip case manager to deal autonomously with the diverse needs of clients
- Limited mix of services available to clients
- Limited array of outcomes or solutions for client problems

Informal Partnership

Characteristics

- Establishes and maintains informal partnerships or networks to respond to the needs of multiple populations with multiple problems
- Initial motivation for forming partnerships may have been funding-driven as well as need-driven
- Front-line case management staff from partnership agencies meet informally as a group (and without a formal contractual obligation) to discuss client cases
- Supervisors and other staff also may become involved and form relationships to share client-related concerns
- Staffing decisions are made internally by individual agencies
- May evolve from a single agency model or be the model of choice from program inception
- Less likely to have a lead agency than a formal consortium

Positive Features

- Meets and functions only as needed
- Avoids overlap of services
- Has access to broader set of resources than single agency model
- Coordinates care better among agencies at client level
- Counters staff's feelings of isolation by sharing burden of client responsibility
- Shares information and possibly resources with partner agencies

Negative Features

- Multiple problem orientations of partnership members may conflict with one another
- More opportunity to compromise individual agency goals with respect to clients
- Not as quick to respond to emerging problems as single agency model case management
- Investment of staff and time resources greater than for single agency models (e.g., time to attend meetings)
- Possible breakdown of service coordination among multiple providers may result in service gaps and fragmented care
- Clients may find it difficult to relate to multiple providers

Formal Consortium

Characteristics

- Two or more providers linked by a formal contractual arrangement
- Represents multiple values and philosophies
- Agencies cooperate and work together for a common purpose, which is formalized in the

contractual relationship
- Agencies represent or cover multiple resources (e.g., housing and employment) in a particular social service market
- Typically identifies a lead agency (often the agency that funds or obtained the funds for case management services) to coordinate the consortium's case management services
- The case manager may be supported through pooled resources from members of the consortium or by the lead agency
- The lead agency generally hires the case manager, although multiple agencies within the consortium may participate in the selection process
- Accountability is shared across agencies
- Case manager is accountable to the consortium
- Entities primarily responsible for building and supporting the consortium (e.g., United Way; State, county, or city government; National Institutes of Health; or Centers for Disease Prevention and Control) may impose conditions or constraints on the case management process (e.g., mandated community involvement)
- Takes time and effort to develop; requires substantial up-front investment
- Focuses more on organizational process than other interagency case management models
- Tends to have a longer-term or more chronic orientation than other case management models

Positive Features

- Access to more resources
- Broader structure of constituent, political, and community support when resources are limited or the economy is strained
- More control in shaping the environment in which services are provided (e.g., more input into and control over policies, funding, and the kind of case management interventions and services that are offered)
- More opportunities for coordination of care among agencies at both client and system level
- Regularized contact between agencies increases occasions for strengthening service integration
- Enhanced coordination across providers can decrease duplication of services
- Consortium participants share information regarding changes in the organizational environment, available and declining resources, and treatment information

Negative Features

- Can be slow to respond due to problems of coordination
- Must contend with multiple definitions of a problem or solution that may spark conflict among consortium members
- Time devoted to organizational process may reduce time given to client-related tasks
- Clients may find it difficult to relate to multiple providers
- Clients may need to travel to several locations for services
- Multiple agency participation per case may involve higher costs and less intense personnel/agency involvement, without added benefit to client
- Potential systemic conflict over which agency takes lead and whose philosophy prevails

when differences occur